| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265160 | A. Building<br>B. Wing | 08/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lewis & Clark Gardens | 1221 Boones Lick Road<br>Saint Charles, MO 63301 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530<br><br>Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for one resident (Resident #135), in a review of 18 sampled residents, when staff failed to recognize the resident's need for portable oxygen when out of in his/her room, failed to ensure the resident had means for locomotion after his/her requests for a wheelchair due to his/her shortness of breath, and failed to recognize the resident's use of a cardiac (heart) monitor for his/her pacemaker (surgically implanted device to control an irregular heart rhythm) and to contact the physician for orders to continue use of the monitoring device. The facility census was 82.<br><br>During an interview on 08/08/24, the Director of Nursing said the facility did not have a policy for accommodation of needs.<br><br>1. Review of Resident #135's undated Continuity of Care Document (CCD) showed the following:<br><br>-He/She was admitted to the facility on [DATE];<br><br>-Diagnoses included shortness of breath and disease of the pulmonary vessel (conditions affecting lung blood vessels).<br><br>Review of the resident's Admission Clinical Assessment, completed by the licensed nurse, dated 07/31/24, showed the following:<br><br>-The resident was oriented to person, place, and time;<br><br>-The resident was independent with decision making;<br><br>-The resident required one person assistance with transfers and when walking in his/her room and on the unit;<br><br>-A wheelchair was the resident's primary mode of locomotion;<br><br>-The resident fell within the previous 30 days;<br><br>-The resident had a pacemaker;<br><br>-The resident wore oxygen at 3 liters per nasal cannula.<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 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the resident's Care Plan, dated 7/31/24, showed the following:<br><br>-He/She was at risk for falls;<br><br>-Interventions included implementation of an exercise program that targeted strength, gait, and balance, and increased staff supervision with intensity based on resident's needs.<br><br>(The resident's care plan did not address if the resident walked or required a wheelchair, the resident's oxygen use or the resident's pacemaker.)<br><br>Review of the resident's Functional Abilities Assessment completed by nursing staff, dated 08/01/24, showed the following:<br><br>-He/She required partial to moderate assistance with chair to bed and bed to chair transfers;<br><br>-He/She required partial to moderate assistance with transferring on and off toilet;<br><br>-His/Her ability to ambulate at least 10 feet in a room, corridor or similar space was not attempted due to medical condition or safety concerns;<br><br>-His/Her ability to walk 150 feet in a corridor or similar space was not attempted due to medical condition or safety concerns;<br><br>-He/She was independent with wheeling 50 feet with two turns once seated in a manual wheelchair;<br><br>-He/She was independent with wheeling 150 feet with two turns once seated in a manual wheelchair.<br><br>Review of the resident's Nurses Note, dated 8/01/24 at 12:03 P.M., showed the following:<br><br>-The resident was a new admit;<br><br>-Alert and oriented and able to make his/her needs known;<br><br>-The resident required oxygen therapy at 2 liters per minute.<br><br>Review of the resident's physician's orders, dated 8/5/24, showed an order for continuous oxygen at 3 liters per minute per nasal cannula.<br><br>During an interview on 08/05/24 at 11:30 A.M., the resident said the following:<br><br>-He/She had been in his/her room since his/her admission on 8/1/24;<br><br>-He/She was very upset that staff had not offered him/her a wheelchair and portable oxygen to use;<br><br>-He/She attempted to walk without assistance to the dining room yesterday without his/her oxygen and became very dizzy, short of breath, and barely made it back to his/her room where his/her oxygen (concentrator) was located;<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She had to get out of his/her room and had requested portable oxygen, but staff did not provide it;<br><br>-He/She was not wanting to stay in his/her room and was not in prison, and that was how he/she felt;<br><br>-He/She had a pacemaker and had a heart monitor that monitored heart rhythm that needed to be plugged in. He/She used the monitor at home, but had not used it since he/she was admitted to facility.<br><br>Observation on 08/05/24 at 11:30 A.M. showed the following:<br><br>-There was no portable oxygen tank located in the resident's room;<br><br>-There was no wheelchair for the resident to use located in his/her room;<br><br>-There was a heart monitor box located on the resident's bedside table.<br><br>Review of the resident's Nurse's Note, dated 08/06/24 at 10:58 A.M., showed the following:<br><br>-The resident's diagnoses included coronary obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and acute hypercapnic respiratory failure (condition caused by too much carbon dioxide in the blood);<br><br>-He/She was at moderate risk for falls;<br><br>-He/She was not currently enrolled in therapy services;<br><br>-He/She was alert and oriented, and able to make his/her needs known.<br><br>Observation on 08/6/24 at 5:00 P.M. showed the following:<br><br>-The resident was not in his/her room;<br><br>-A portable oxygen tank sat in a wheeled carrier in the room with no tubing attached;<br><br>-There was no wheelchair in the resident's room;<br><br>-There was a heart monitor box located on the resident's bedside table.<br><br>Observation on 08/6/24 at 5:00 P.M. showed the following:<br><br>-The resident sat in a chair in the dining room;<br><br>-The resident did not have any supplemental oxygen;<br><br>-He/She did not have a wheelchair or a walker.<br><br>During an interview on 08/6/24 at 5:00 P.M., the resident said the following:<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He/She was not in prison and was not staying in his/her room;<br><br>-He/She walked to the dining room without a wheelchair and/or walker;<br><br>-A wheelchair and/or a seated walker would be beneficial as he/she would feel safer and could stop and sit down if he/she had increased shortness of breath while walking;<br><br>-The facility had not provided him/her with a wheelchair despite his/her requests.<br><br>During an interview on 08/05/24 at 5:20 P.M., Certified Medication Technician (CMT) N said he/she was unaware the resident needed a heart monitor and portable oxygen.<br><br>During an interview on 08/05/24 at 5:20 P.M., Certified Nursing Assistant (CNA) I said he/she was unaware the resident needed a heart monitor, wheelchair, and portable oxygen.<br><br>During an interview on 08/05/24 at 5:20 P.M., Licensed Practical Nurse (LPN) O said the following:<br><br>-He/She was an agency nurse and this was his/her first time working at the facility;<br><br>-He/She was unaware of the resident's need for a heart monitor;<br><br>-He/She had not received any additional information from the previous shift.<br><br>During an interview on 08/08/24 at 11:30 A.M., the Director of Therapy Services said staff asked him/her about a wheelchair for this resident prior to the resident's arrival. She did not recall who inquired about the wheelchair, but instructed staff there were extra wheelchairs in the maintenance office that could be used if needed. She had not had evaluated this resident.<br><br>During interview 08/6/24 at 5:30 P.M., the Director of Nursing said the following:<br><br>-She was not familiar with this resident;<br><br>-She was off when the resident was admitted , and she had not had a chance to visit with him/her yet;<br><br>-She thought the resident was admitted with exacerbation of COPD;<br><br>-She was unaware the resident had a heart monitor;<br><br>-Nursing staff should be aware if the resident brought this equipment, including a heart monitor with him/her when he was admitted , and contact the resident's physician for any orders for use;<br><br>-The facility provided residents with a wheelchair upon admission if needed;<br><br>-She was not sure if the resident was provided a wheelchair as she was not familiar with this resident and had not had a chance to visit with him/her;<br><br>-She expected staff to provide the resident with a wheelchair if needed and/or requested. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>44665<br><br>Based on observation and interview, the facility failed to ensure hazardous materials were kept secured and inaccessible to residents. The facility capacity was 142 and the census was 82.<br><br>Observation on 8/5/24 from 11:28 A.M. to 6:58 P.M., during the life safety code tour of the facility, showed the following:<br><br>-Six containers of chafing fuel were in an unlocked cabinet in the 200 hall dining and activity room;<br><br>-A bottle of nail polish remover was in an unlocked lower cabinet in the ice cream/popcorn area located near the resident sitting area. The nail polish remover bottle label read '100% pure acetone, Warning: Keep away from children, Danger! Extremely flammable!;<br><br>-A bottle of commercial surface disinfectant was in a lower unlocked cabinet in the 100/200 wing dining room. The label on the bottle read 'Keep out of reach of children';<br><br>-An unlabeled spray bottle containing purple liquid was in an unlocked cabinet near the lobby restrooms and resident sitting area;<br><br>-An unlabeled spray bottle containing yellow liquid and a bottle of liquid starch were in an unlocked cabinet below the television in the main dining room.<br><br>During interviews on 8/5/24 at 5:08 P.M. and on 8/7/24 at 2:30 P.M., the Maintenance Supervisor said he was unaware of the items found unsecured during the life safety code tour and he expected the items to be secured from access by residents. He recognized the yellow liquid as a cleaner and the purple liquid a deodorizer - both liquids were products utilized at the facility. He expected liquids such as these to be labeled. The nail polish remover, and starch were likely used by the activities staff.<br><br>During an interview on 8/7/24 at 2:01 P.M., the Activities Director said she had only worked at the facility for a couple of weeks and was unaware the items found during the life safety code tour needed to be secured from resident access. |

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F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide safe and appropriate respiratory care for a resident when needed.

**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530

Based on observation, interview, and record review, the facility failed to ensure six residents (Residents #135, #136, #3, #22, #3, #43, and #42), in a review of 18 sampled residents, received respiratory therapy/care consistent with professional standards of practice and the residents' plan of care. The facility failed to administer Resident #135's oxygen per physician's orders, failed to obtain orders for his/her CPAP machine upon the resident's admission to the facility, and failed to label oxygen tubing per the resident's physician's orders. The facility failed to apply Resident #136's BiPAP as ordered, failed to label Resident #3's oxygen tubing and humidification, and failed to properly store nebulizer masks when not in use for Residents #22, #43 and #42. The facility census was 82.

Review of the facility's undated policy, Oxygen Administration, showed the following:

-Humidification bottles should be labeled with the date and time they were opened;

-Place cannula tubing in plastic bag attached to the concentrator when tubing was not in use;

(The facility's policy did not provide any direction on labeling oxygen tubing.)

1. Review of Resident #135's hospital referral, dated 07/31/24, showed the following:

-The resident's diagnoses included chronic obstructive pulmonary disease (COPD/a chronic respiratory illness), shortness of breath, and obstructive sleep apnea (obstruction of upper airway which causes reduced or absence of breathing when sleeping);

-The resident had used a CPAP machine (machine that helps keep airways open while sleeping) since 04/14/24.

Review of the resident's Continuity of Care Document (CCD) showed the following:

-The resident was admitted on [DATE];

-The resident's diagnoses included shortness of breath and disease of the pulmonary vessels (group of disorders that affect the blood vessels in the lungs).

Review of the resident's personal belongings inventory list, dated 07/31/24, showed the resident had a CPAP machine in his/her possession upon admission to the facility.

Review of the resident's physician's orders on admission, dated 07/31/24, showed no documentation the resident received oxygen therapy and utilized a CPAP machine.

Review of the resident's baseline care plan, dated 07/31/24, showed no documentation the resident received oxygen therapy and used a CPAP machine.

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's Physician's Orders, dated 8/1/24 through 8/4/24, showed no documentation the resident received oxygen therapy.<br><br>Review of the resident's nursing progress notes, dated 08/01/24 at 12:03 P.M., showed the resident was a new admission to the facility and wore oxygen at 2 liters. (The resident did not have a physician's order for oxygen therapy on 8/1/24.)<br><br>Review of the resident's nursing progress notes, dated 08/02/24 at 8:58 A.M., showed the resident wore oxygen at 2 liters via nasal cannula. (The resident did not have a physician's order for oxygen therapy on 8/2/24.)<br><br>Review of the resident's nursing progress notes, dated 08/03/24 at 1:26 P.M., showed the resident wore oxygen at 2 liters via nasal cannula. (The resident did not have a physician's order for oxygen therapy on 8/3/24.)<br><br>Review of the resident's nursing progress notes, dated 08/04/24 at 9:21 A.M., showed the resident wore oxygen at 2 liters via nasal cannula. (The resident did not have a physician's order for oxygen therapy on 8/4/24.)<br><br>Review of the resident's physician's orders, dated 08/05/24, showed the following:<br><br>-Oxygen, 3 liters per minute per nasal cannula continuous every shift (original order dated 08/05/24);<br><br>-Change oxygen tubing weekly on Sunday night and date all tubing when changed (original order dated 08/05/24);<br><br>(Review showed no documentation the resident's needed a CPAP.)<br><br>During an interview on 08/05/24 at 1:11 P.M., the resident said the following:<br><br>-He/She was upset with the facility because he/she was supposed to use a CPAP at night, but the staff had not assisted him/her with setting up the machine after he/she voiced he/she needed one;<br><br>-He/She could set it up, but he/she had nowhere to place it and was not going to sit it on the dirty floor.<br><br>Observation on 08/05/24 at 1:00 P.M. showed the following:<br><br>-The resident sat on his/her bed with oxygen in place at 2 liters via nasal cannula;<br><br>-The resident's oxygen tubing was not dated;<br><br>-A black bag lay on the resident's bed which contained the resident's CPAP machine.<br><br>During an interview on 08/05/24 at 5:20 P.M., Certified Medication Technician (CMT) N said he/she was unaware of the resident's need for a CPAP at night. Licensed nurses were responsible for putting the CPAP machines on the residents at night.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/05/24 at 5:20 P.M., Certified Nursing Assistant (CNA) I said he/she was unaware the resident needed a CPAP at night. The licensed nurses were responsible for putting the CPAP machines on the residents at night.<br><br>During an interview on 08/05/24 at 5:20 P.M., Licensed Practical Nurse (LPN) O (nurse responsible for putting the CPAP on the resident on 05/05/24) said he/she was an agency nurse and this was his/her first time working at the facility. He/She was unaware of the resident's need for a CPAP machine. He/She had not received any additional information in report from the previous shift regarding a CPAP.<br><br>Observation on 8/6/24 at 4:48 P.M. showed the following:<br><br>-The resident was not in his/her room;<br><br>-The resident's oxygen tubing attached to the oxygen concentrator was not labeled.<br><br>Observation on 08/06/24 at 5:00 P.M., showed the resident sat at the dining room table without supplemental oxygen. (The resident's physician's orders showed the resident was to receive continuous oxygen at 3 liters per minute.)<br><br>During an interview on 08/06/24 at 5:00 P.M., the resident said the following:<br><br>-He/She walked to the dining room without difficulty breathing this time, but has had shortness of breath the past;<br><br>-Staff provided him/her with a portable oxygen tank with no tubing and no way to transport it as he/she did not use a wheelchair;<br><br>-His/Her CPAP machine had not been set up after he/she had told multiple nurses.<br><br>During an interview on 08/06/24 at 5:30 P.M., the Director of Nursing (DON) said the following:<br><br>-She was not familiar with this resident;<br><br>-She was off when the resident was admitted and had not had a chance to visit with him/her yet;<br><br>-She thought the resident's diagnoses upon admission was exacerbation of COPD;<br><br>-She was not aware of the resident's need for a CPAP machine;<br><br>-She expected staff to be aware if the resident came with a CPAP machine and notify the physician for any orders.<br><br>Observation on 08/07/24 at 4:15 A.M., showed the following:<br><br>-The resident lay in his/her bed with his/her nasal cannula tubing in his/her nostrils;<br><br>-The tubing was not labeled;<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The resident's oxygen concentrator was set to 2 liters of oxygen. (The resident's physician's orders showed the resident was to receive oxygen at 3 liters per minute.)<br><br>2. Review of Resident #136's CCD showed he/she was admitted to the facility on [DATE].<br><br>Review of the resident's admission MDS, dated [DATE], showed the following:<br><br>-The resident's cognition was moderately impaired;<br><br>-Diagnoses included chronic lung disease and heart failure;<br><br>-The resident did not require a CPAP on admission or while a resident;<br><br>-The resident required substantial/maximum assistance with moving from sitting to standing position;<br><br>-The resident required partial/moderate assistance with transferring from chair/bed to chair;<br><br>-The resident required substantial/maximum assistance with walking 10 feet.<br><br>Review of the resident's Care Plan, last reviewed/revised 07/11/24, showed the following:<br><br>-The resident required one-person physical assistance with transfers;<br><br>-The resident required the use of a wheelchair and assistance of one staff with locomotion.<br><br>(The care plan did not include any documentation the resident used a BiPAP (a machine that helps breathing by pushing air into the lungs) machine at night.)<br><br>Review of the resident's physician's order, dated 07/25/24, showed an order for a BIPAP machine to be applied every night at bedtime.<br><br>Observation on 08/05/24 at 2:30 P.M., showed a BiPAP machine lay on the resident's bedside table at the foot of the resident's bed. The BiPAP mask lay uncovered on top of the machine.<br><br>During an interview on 08/05/24 at 2:30 P.M., the resident said the following:<br><br>-He/She had not worn the BiPAP since he/she was admitted ;<br><br>-He/She felt more tired which was likely due to not wearing the BiPAP at night;<br><br>-He/She had worn it for [AGE] years and needed it to rest.<br><br>Observation on 8/7/24 at 4:25 A.M. showed the following:<br><br>-The resident lay asleep in his/her bed;<br><br>-The resident was not wearing the BiPAP mask;<br><br>(continued on next page) |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The resident's BiPAP machine rested on the resident's bedside table and the uncovered mask lay on top of the machine.<br><br>During an interview 8/7/24 at 5:00 A.M., LPN K (the night shift nurse) said the following:<br><br>-He/She was an agency nurse and was not familiar with the residents;<br><br>-He/She was not aware of any residents who required a BiPAP;<br><br>-The evening shift nurse was responsible for applying CPAP and BiPAP(s) to the residents;<br><br>-He/She looked at the resident's physician's orders and found an order for BiPAP to be applied every night;<br><br>-He/She did not check to ensure the BiPAP was applied and working properly.<br><br>During an interview on 08/07/24 at 5:20 A.M., CNA J said the following:<br><br>-The resident wore a CPAP, but was able to put it on himself/herself;<br><br>-The resident was physically able to stand up out of bed, walk to the bedside table, obtain the CPAP mask, apply the mask, and turn the machine on himself/herself. (Review of the resident's MDS showed the resident required assistance with transfers and locomotion.)<br><br>During an interview 08/7/24 at 6:37 A.M., the resident said the following:<br><br>-He/She did not wear his/her BiPAP last night;<br><br>-No one placed it on him/her since he/she was admitted to the facility;<br><br>-He/She could not walk to the bedside table to obtain the machine to apply it himself/herself;<br><br>-He/She needed the BiPAP to sleep better and had been more tired due to not wearing it.<br><br>3. Review of Resident #3's quarterly MDS, dated [DATE], showed the following:<br><br>-The resident's cognition was intact;<br><br>-The resident's diagnoses included chronic lung disease;<br><br>-The resident required oxygen therapy while he/she resided at the facility.<br><br>Review of the resident's Care Plan, last reviewed on 07/24/24, showed no documentation the resident used oxygen therapy.<br><br>Review of the resident's CCD, dated 08/06/24, showed his/her diagnoses included COPD and malignant neoplasm (cancer) of the bronchus or lung.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's Physician's Orders, dated August 2024, showed and order for oxygen therapy at 2 liters per nasal cannula to keep saturations greater than 90% (original order dated 6/24/24).<br><br>Observation on 8/5/24 at 1:00 P.M. showed the following:<br><br>-The resident wore an undated oxygen cannula in his/her nostrils;<br><br>-The humidification bottle with clear liquid in the chamber was attached to the oxygen concentrator and was not labeled.<br><br>Observation on 8/6/24 at 4:00 P.M. showed the following:<br><br>-The resident wore undated oxygen cannula in his/her nostrils;<br><br>-The humidification bottle with clear liquid in the chamber was attached to the oxygen concentrator was not labeled.<br><br>Observation on 8/7/24 at 4:20 A.M. showed the following:<br><br>-The resident wore undated oxygen cannula in his/her nostrils;<br><br>The humidification bottle with clear liquid in the chamber was attached to the oxygen concentrator was not labeled.<br><br>Observation on 8/8/24 at 11:55 A.M. showed the following:<br><br>-The resident wore undated oxygen cannula in his/her nostrils;<br><br>The humidification bottle with clear liquid in the chamber was attached to the oxygen concentrator was not labeled.<br><br>4. Review of Resident #22's quarterly MDS, dated [DATE], showed the following:<br><br>-The resident's cognition was intact;<br><br>-The resident's diagnoses included chronic lung disease.<br><br>Review of the resident's CCD, dated 08/06/24, showed the resident's diagnoses included chronic respiratory failure with hypoxia (low oxygen in the blood), cough, shortness of breath, dependence on other enabling machines and devices, and COPD.<br><br>Review of resident's physician's orders, dated August 2024, showed an order for Ipratropium-Albuterol (inhaled medication used to make breathing easier) 0.5 milligrams (mg)/3 milliliters (ml); inhale 3 ml via nebulizer four times a day (QID).<br><br>Observation on 08/06/24 at 10:00 A.M. showed the resident's uncovered nebulizer mask lay on the resident's bedside table.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 08/7/24 at 5:00 A.M. showed the following:<br><br>-The resident's uncovered nebulizer mask lay on the floor beside the resident's bed;<br><br>-The resident's nebulizer machine was on the floor beside the resident's bed;<br><br>5. Review of Resident #43's POS, dated August 2024, showed the following:<br><br>-Diagnoses included cough and pneumonitis (inflammation of lung tissue);<br><br>-Ipratropium/albuterol solution for nebulization 0.5 mg/3 mg (2.5 mg base)/3 ml one vial inhalation four times daily.<br><br>Observation on 8/6/24 at 2:30 P.M. showed the following:<br><br>-The resident lay in his/her bed;<br><br>-A nebulizer machine sat on the floor between the wall and the resident's bed. The machine was on and the nebulizer treatment was attached;<br><br>-The DON entered the room, turned off the machine, moved the machine to the table across the room and gave the resident a pain pill;<br><br>-The DON exited the room without cleaning or bagging the nebulizer equipment.<br><br>Observation on 8/7/24 at 4:30 A.M. showed the resident lay in his/her bed. The nebulizer mask lay on the table across the resident's room, unbagged and was connected to the machine.<br><br>6. Review of Resident #42's POS, dated August 2024, showed the following:<br><br>-Diagnoses included cough and COPD;<br><br>-Albuterol sulfate solution for nebulization 2.5 mg/3 ml. (0.083%) one vial via inhalation every six hours.<br><br>Observation on 8/6/24 at 3:20 P.M. showed a nebulizer mask was attached to the medication reservoir and the tubing lay unbagged on the table across from the bed.<br><br>Observation on 8/7/24 at 5:00 A.M. showed the resident lay in his/her bed. A nebulizer mask attached to the medication reservoir and tubing lay unbagged on the table across from the bed.<br><br>7. During an interview on 08/21/24 at 2:30 P.M., the Director of Nursing said the following:<br><br>-The night nurse should change the oxygen tubing and humidification every Sunday night;<br><br>-Staff should label oxygen tubing and humidification with the date it was started;<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Staff should store oxygen tubing and nebulizer masks in plastic bags attached to the machine and/or close by the machine when not in use;<br><br>-Nursing staff were responsible for ensuring that oxygen tubing and nebulizer masks were stored appropriately, but other staff should be aware if it was improperly stored, and notify the charge nurse and/or place the equipment in the proper storage bag;<br><br>-Nebulizer machines should not be on the floor when a treatment was being administered;<br><br>-The evening nurse or the night nurse should place CPAPs and BiPAP on residents as ordered;<br><br>-Some residents could put on their own CPAP and/or BiPAP machine, but it was the nurse's responsibility to ensure the resident had the machine applied correctly;<br><br>-Nursing staff should contact the resident's physician for orders if the resident presented to the facility with a CPAP machine.<br><br>During an interview on 08/08/24 at 5:00 P.M., the Administrator said the following:<br><br>-Staff should store nebulizer masks in plastic bags when not in use;<br><br>-Staff should replace nebulizer masks if found lying on the floor;<br><br>-Licensed nurses were responsible for putting on the residents' BiPAP and/or CPAP at night and were expected to follow physician's orders;<br><br>-Staff should label oxygen tubing and humidification bottles when opened.<br><br>32899 |

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F 0804

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

45563

Based on observation, interview, and record review, the facility failed to ensure staff served food that was palatable and at an appetizing temperature. The facility census was 82.

Review of the facility policy, Food Temperatures, dated April 2011, showed the following:

-Hot foods should be at least 120 degrees F when served to the resident;

-Place cold menu items in the steam table over an ice bath with the well of the steam table turned off.

1. During an interview on 08/06/24 at 10:23 A.M., Resident #135 said the food did not taste good.

During interview on 8/6/24 at 10:35 A.M., Resident #72 said the food was often bland.

During interview on 8/5/24 at 2:50 P.M., Resident #67 said the food was cold and had no seasoning.

2. Review of the spreadsheet menu on 8/5/24 showed the dinner meal included barbeque pork and pasta salad.

Review of the recipe for the pasta salad showed to hold the temperature at 41 degrees or lower for the meal service.

Observation on 8/5/24 at 5:04 P.M. showed the Dietary Manager identified Dietary [NAME] W had not prepared the pasta salad from the dinner meal. Dietary [NAME] W placed the dry pasta in water on the stovetop. At 5:13 P.M., Dietary [NAME] W drained the boiling water from the pasta in the sink and ran cold water over the pasta. Dietary [NAME] W said he/she was trying to cool the pasta down. Observation showed Dietary [NAME] W placed the pasta into a pan. Steam came off the pasta. He/She poured a bottle of Italian dressing over the pasta and placed it on the steam table (not over an ice bath). He/She then began serving the dinner meal from the steam table.

Observation on 8/5/24 at 6:30 P.M. showed the dinner meal service ended. Staff took the temperature of the barbeque pork from the steam table. The pork was 100 degrees F. Observation showed the steam table heating unit under the pork was not turned on. The temperature of the pasta salad was 85 degrees F.

3. Observation on 8/6/24 at 12:17 P.M. showed Dietary Aide V opened large cans of sliced potatoes and put the potatoes in a pan on the stovetop. At 12:20 P.M., the Dietary Manager placed the pan of potatoes on the steamtable. He/She served 37 residents the potatoes instead of the cornbread stuffing.

During interview on 8/6/24 at 12:33 P.M., Dietary Aide V said he/she did not add any seasoning to the potatoes.

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 8/6/24 at 1:07 P.M. of the test tray, showed the temperature of the potatoes was 110 degrees F. The potatoes were very bland and had no flavor.<br><br>During an interview on 8/6/24 at 1:30 P.M., Resident #14 said he/she was supposed to have received stuffing for his/her meal, but received potatoes instead. The potatoes had no flavor.<br><br>During interview on 8/6/24 at 1:30 P.M., Resident #72 said the potatoes had no flavor.<br><br>(The facility did not provide a recipe for the potatoes. The potatoes were a substitute for the cornbread which was on the spreadsheet menu for the lunch meal.)<br><br>4. During interview on 8/8/24 at 1:30 P.M., the Dietary Manager said staff only take the temperature of food when they put it on the steamtable at the beginning of the meal service. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>45563<br><br>Based on observation, interview, and record review, the facility failed to prepare pureed food items according to the recipe to ensure the puree was a smooth consistency. The facility identified one resident on a pureed diet. The facility census was 82.<br><br>Review of the facility policy, Types of Diets, dated April 2011, showed for a pureed diet, foods should be blended to a mashed potato consistency or altered to meet the needs of the resident, using as little liquid as possible.<br><br>Review of the Resident Orders, dated 8/6/24, showed one resident had a physician order to receive a pureed diet.<br><br>1. Observation on 8/5/24 at 12:04 P.M. showed the Dietary Manager prepared the pureed meal tray from the steam table. The pureed chicken was the consistency of ground chicken with visible chunks of chicken, and the pureed carrots contained visible chunks of carrots.<br><br>2. Review of the recipe for pureed barbeque pork showed to process until smooth.<br><br>Observation on 8/5/24 at 5:13 P.M. showed the Dietary Manager prepared pureed barbeque pork in the food processor. Pieces of the pulled pork were visible in the pureed mixture; the mixture was stringy.<br><br>3. Review of the recipe for pureed pasta salad showed to place the pasta salad in the food processor and process until smooth.<br><br>Review of the recipe for pureed green beans (provided as the recipe for three-bean salad) showed to process until smooth.<br><br>Observation on 8/5/24 at 5:40 P.M. showed Dietary [NAME] W prepared the pureed three-bean salad and pureed pasta. He/She added the beans to the food processor. The pureed beans contained chunks of beans. He/She then prepared the pureed pasta (the only liquid was the Italian dressing already on the pasta). The pureed pasta was a thick consistency with chunks of pasta in the mixture.<br><br>4. Review of the recipe for pureed roast turkey showed to prepare the turkey according to recipe. Add thickener and water/stock and prepare a slurry. Process turkey until smooth adding 1 ounce slurry per portion.<br><br>Observation on 8/6/24 at 12:05 P.M., of the pureed test tray, showed the pureed turkey was the consistency of ground turkey, was thick and required chewing.<br><br>5. During interview on 8/5/24 at 4:47 P.M., the Dietary Manager said pureed food should be the consistency of baby food with no chunks.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 8/7/24 at 9:47 A.M., the Speech Therapist said pureed food should be the consistency of applesauce and should not have any chunks or require chewing. |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899<br><br>Based on interview and record review, the facility failed to ensure staff offered nourishing evening snacks for residents who wished to have a snack for seven residents (Resident #3, #46, #43, #47, #54, #135 and #72), in a review of 18 sampled residents, and for two additional residents (Residents #13 and #67). The facility also failed to ensure all residents were provided equal opportunity to have a snack. The facility census was 82.<br><br>Review of the facility's undated policy, Menus, showed a bedtime snack shall be offered to all residents per federal and state regulations.<br><br>1. Review of Resident #3's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 10/9/23, showed the following:<br><br>-Cognition was intact;<br><br>-He/She considered it very important to have snacks between meals.<br><br>Review of the resident's Physician's Orders, dated August 2024, showed an order for staff to offer/provide bedtime snacks to the resident daily.<br><br>During an interview on 8/6/24 at 4:00 P.M., the resident said the following:<br><br>-The facility did not provide bedtime snacks;<br><br>-He/She would love to have a bedtime snack.<br><br>2. Review of the Resident #46's annual MDS, dated [DATE], showed the following:<br><br>-Cognition was moderately impaired;<br><br>-He/She considered it very important to have snacks between meals.<br><br>Review of the resident's Physician's Orders, dated August 2024, showed an order for staff to offer/provide bedtime snacks to the resident daily.<br><br>During an interview on 8/6/24 at 4:00 P.M., the resident said the following:<br><br>-The facility did not provide bedtime snacks;<br><br>-He/She would love to have a bedtime snack.<br><br>3. Review of Resident #43's significant change MDS, dated [DATE] showed it was very important to the resident to have snacks between meals.<br><br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the resident's Physician's Orders, dated August 2024, showed staff were to offer the resident a bedtime snack.<br><br>During an interview on 8/5/24 at 12:59 P.M., the resident said staff did not offer him/her snacks and there were times he/she would like a snack in the evening.<br><br>4. Review of Resident #47's admission MDS, dated [DATE], showed it was very important to the resident to have snacks between meals.<br><br>Review of the resident's quarterly MDS, dated [DATE] showed the following:<br><br>-Cognitively intact;<br><br>-Independent with eating.<br><br>Review of the resident's Physician's Orders, dated August 2024, showed staff were to offer the resident a bedtime snack.<br><br>During an interview on 8/5/24 at 1:47 P.M., the resident said the following:<br><br>-Staff do not offer bedtime snacks. Staff do not go room to room offering snacks;<br><br>-If he/she wanted a snack, he/she had to ask staff for one.<br><br>5. Review of Resident #54's annual MDS, dated [DATE], showed the following:<br><br>-Cognitively intact;<br><br>-Independent with eating;<br><br>-Very important to have snack between meals.<br><br>Review of the resident's Physician's Orders, dated August 2024, showed the following:<br><br>-Diagnoses included diabetes;<br><br>-Offer a bedtime snack.<br><br>During an interview on 8/5/24 at 12:38 P.M., the resident said the following:<br><br>-Staff delivered snacks to the nurse's station after supper;<br><br>-Staff only brought out a small amount of snacks (around ten);<br><br>-If he/she wanted a snack, he/she had to go to the nurses station to get a snack;<br><br>-If he/she did not get to the nurses station early, he/she would not get a snack.<br><br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 6. Review of Resident #135's Physician's Orders, dated August 2024, showed an order for staff to offer/provide bedtime to the resident daily.<br><br>During an interview on 8/6/24 at 4:00 P.M., the resident said the following:<br><br>-The facility did not provide bedtime snacks;<br><br>-He/She would like to have a bedtime snack.<br><br>7. During interview on 8/5/24 at 2:50 P.M., Resident #67 said staff do not offer him/her a bedtime snack. He/She did not know if there were snacks at the nurses station.<br><br>During interview on 8/5/24 at 3:00 P.M., Resident #13 said staff do not offer the residents a bedtime snack. Dietary staff took snacks to the nurses station, and the residents had to go to the nurses station to get their snack. There was usually not enough snacks for everyone to get one.<br><br>During interview on 8/6/24 at 10:35 A.M., Resident #72 said staff take the bedtime snacks to the nurses desk. The residents have to go get the snacks themselves. Sometimes, there weren't any snack available at bedtime; the snacks were already gone when he/she went to the nurses desk.<br><br>8. During an interview on 8/8/24 at 2:07 P.M., Certified Nursing Assistant (CNA) I (who worked on the evening shift) said the residents do not get bedtime snacks. He/She was not sure why.<br><br>During interview on 8/8/24 at 1:30 P.M., the Dietary Manager said the evening dietary aides filled plastic bags with different snacks and took them to the nurses stations for the bedtime snack.<br><br>During an interview on 08/21/24 at 2:30 P.M., the Director of Nursing said staff should offer all residents a bedtime snack. Staff should bring the snacks from the kitchen, and the CNAs should deliver the snacks to the residents. She didn't think the CNAs were aware that all residents were supposed to be offered a snack.<br><br>During an interview on 8/8/24 at 4:50 P.M., the Administrator said staff should offer all residents a bedtime snack. Staff should bring the snacks from the kitchen, and the CNAs should deliver the snacks to the residents. She not aware staff were not offering or providing bedtime snacks. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>45563<br><br>Based on observation, interview, and record review, the facility failed to ensure the kitchen was clean and maintained in a manner to ensure the safe storage, preparation, and distribution of food. Staff failed to wash hands and utilize gloves appropriately during meal preparation and service, failed to properly wash dishes in the three-compartment sink and ensure sanitizer solution was available for use, failed to properly clean food preparation surfaces with sanitizing solution, and failed to ensure the temperature in one freezer was at least 0 degrees Fahrenheit or below. The facility census was 82.<br><br>1. Review of the Registered Dietician's Kitchen Observation, dated 7/22/24, showed the following:<br><br>-Open food items were not stored or properly sealed and labeled and dated;<br><br>-Not all food was properly covered, labeled or dated;<br><br>-The stove/oven was not clean. The front of the stove needs cleaned;<br><br>-The microwave was not clean;<br><br>-The cooler/freezer was not clean. Food debris was on the floor of the reach-in cooler/freezer;<br><br>-The walls were not clean, without damage. The wall behind the dish machine had a dark buildup.<br><br>Observation on 8/5/24 between 11:35 A.M. and 6:30 P.M. showed the following:<br><br>-The floor throughout the kitchen was dirty;<br><br>-The door fronts and the handles to the three-door freezer were soiled;<br><br>-The ceiling on the inside surface of the microwave was heavily soiled with food debris;<br><br>-The fronts and handles of the drawers, located under the preparation counter with the microwave and food processor, were heavily soiled with dried debris;<br><br>-The exterior surfaces of the large, rolling flour and sugar bins, located under the preparation counter with the microwave and food processor, were soiled<br><br>-The wall behind and the ceiling above the food processor were soiled;<br><br>-The tiled wall, located under the preparation counter with the toaster, was heavily damaged. An area of the wall, approximately 12 inches by 12 inches, had been broken away exposing the pipes behind the wall;<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Lewis & Clark Gardens | | STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Boones Lick Road Saint Charles, MO 63301 | |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -The door fronts and the handles to the two-door refrigerator were soiled. The floor inside the refrigerator was soiled with food debris;<br><br>-The plate warmer/holder by the steam table was soiled on the top by where the plates were dispensed and on the base of the unit;<br><br>-The outside surfaces of the steam table covers were soiled;<br><br>-The shelf, located under the preparation table behind the steam table, contained individual serving bowls stored inverted on a tray. The tray was soiled with loose food debris that was in contact with the lips of the bowls. A second tray contained individual bowls of dry cereal that were covered with plastic wrap. The tray, the plastic wrap covering one bowl of cereal, and the floor in front of the preparation table were soiled with an oily substance. The oily substance pooled on the top of the plastic wrap on the bowl of cereal;<br><br>-The plastic food cart cover, located over the metal food cart, was heavily soiled with dried food debris and dried drips/runs. Staff stored the cake for the lunch meal on the metal food cart and reached through the opening in the cover to obtain trays of cake;<br><br>-The built-up concrete platform, located under the range and measured approximately 3 feet by 7 feet, had a very rough surface with chipped and peeling paint and was heavily soiled. The surface was not easily cleanable;<br><br>-The built-up concrete platform, located under the steamer and measured approximately 3 feet by 4 feet, had a very rough surface with peeling paint and was soiled with debris. The surface was not easily cleanable;<br><br>-The shelf under the preparation counter across from the range was soiled with loose food debris. An opened box of contact paper and trays with inverted pitchers and lids were on the shelf. The handles and fronts of the drawers in the preparation counter were soiled;<br><br>-In the dry food storage room, sticky liquid was spilled on the floor under the shelving unit, and loose debris and condiment packets were on the floor throughout the room;<br><br>-The exteriors and the lids on two large trash cans, located on either side of the main food preparation counter, were heavily soiled with dried debris and drips/runs;<br><br>-A portion of the wall under the sink across from the dry food storage room had been cut away, leaving an opening in the wall around the pipes;<br><br>-Black mold-like substance was in the grout along the wall behind the sink in the dishwashing area;<br><br>-The tile floor by the dishwashing area and the walk-in cooler had broken tiles. An area approximately 2 inches by 6 inches of tile had been removed from the floor. The flooring in this area was heavily soiled with a black debris;<br><br>-The shelves on the plate cover racks were soiled with loose food debris;<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 - Many | -A buildup of grease and debris was on the oven doors and around the temperature control knobs;<br><br>-A buildup of debris was on the convection oven doors;<br><br>-Inside the two-door refrigerator, two opened plastic packages of hard-boiled eggs (with liquid inside the packages) lay on their side on a wire shelf above a plastic container of cheese slices. The container of cheese slices had a large crack in the lid;<br><br>-A large, plastic container, approximately half full, was labeled banana pudding and had a preparation date of 7/23. The lid was not sealed on the container;<br><br>-A plastic package of hamburger buns lay on the preparation table behind the steam table. The package, which contained two buns, was ripped and open to air;<br><br>-A 5-pound container of peanut butter sat on the preparation counter. The lid did not fit tightly on the container and peanut butter was on the outside of the lid and along the sides of the container;<br><br>2. Review of the facility policy, Handwashing, dated April 2011, showed turn on water, wet hands and forearms with warm water, lather hands with antiseptic soap, wash hands and forearms, rinse thoroughly with warm water, wipe hands dry with a clean paper towel, turn off water with paper towel and dispose of paper towel.<br><br>Review of the facility policy, Glove Use, dated May 2015, showed the following:<br><br>-Utensils or tongs should be used to serve or handle foods, both raw and cooked, whenever possible.<br><br>-When serving, preference is not to use gloves unless only one task is being performed.<br><br>-Hand washing per guidelines should occur between each task.<br><br>-Gloves should be removed when changing or walking away from specific tasks and hands should then be washed per guidelines.<br><br>-Hands should be washed: (selected items included) after disposing of trash or food, after handling dirty dishes, when changing tasks, and any other time deemed necessary<br><br>Review of the Food and Drug Administration (FDA) Food Code, 2022 edition, showed the following:<br><br>-Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment;<br><br>-If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.<br><br>Review of the Registered Dietician's Kitchen Observation, dated 7/22/24, showed wiping cloths were not stored in sanitizing solution while not in use.<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 - Many | Review of an email correspondence from the Administrator, dated 8/23/24, showed staff were to completely submerge cleaning cloths in the sanitizer solution.<br><br>Observation on 8/5/24 at 3:22 P.M. showed Dietary [NAME] W opened four large cans of pork and beans, lifted the lid on the trash can, put the cans in the trash, removed his/her gloves, put the lid back on the trash can, turned on the faucet at the preparation counter, rinsed his/her hands under the running water, wet a wash cloth under the running water, turned off the water, wiped the spilled beans from the preparation counter with the wet washcloth (did not use sanitizing solution), and then wiped the can opener with the wet wash cloth.<br><br>Observation on 8/5/24 at 4:07 P.M. showed Dietary [NAME] W shredded cooked pork with his/her gloved hands. He/She removed his/her gloves, wiped down the counter with a wet washcloth from the counter (did not use sanitizer), placed the washcloth on the counter, turned on the faucet at the preparation sink, rinsed his/her hands under the running water, turned off the faucet, dumped the bones and pork scraps from the cutting board into the trash can, put the lid on the trash can, turned on the faucet, rinsed his/her hands under the running water, wiped the counter with the wet washcloth that lay on the counter (did not use sanitizer), rinsed his/her hands under the running water and put on gloves. He/She then shredded more cooked pork with his/her gloved hands and placed the pork into a pan, removed his/her gloves, put on oven mitts, opened the oven and put the pan inside. He/She rinsed items in the three-compartment sink under the hose from the soap/water dispenser in the three-compartment sink, turned on the faucet at the preparation counter, rinsed his/her hands, picked up the wet washcloth from the counter, wiped the soiled counter top (soiled with pork), rinsed his/her hands and the washcloth in the soapy water at the three-compartment sink and wiped down the counter.<br><br>Observation on 8/5/24 at 4:50 P.M. showed Dietary [NAME] W washed pans and the cutting board (used to prepare the cook pork) in the soapy water in the middle compartment of the three-compartment sink. He/She rinsed the pans under running water, did not sanitize, and left the pans in the left sink compartment. He/She put on oven mitts , opened the oven, removed the pans of pork from the oven, took off the oven mitts, did not wash his/her hands and put on gloves. He/She checked the temperature of the pork with a thermometer, and then pulled the pork off the thermometer with his/her gloved hand. He/She put on an oven mitt over his/her gloved hand, picked up the pan of barbeque sauce on the stovetop and poured it onto the meat. He/She removed his/her gloves, opened the trash can lid, threw away his/her gloves, turned on the water faucet at the preparation counter and quickly rinsed his/her hands under the running water. He/She then opened a bag of pasta, put it into a pan, turned on the water faucet at the preparation counter, filled a pitcher of water and poured it over the pasta in the pan.<br><br>Observation on 8/5/24 between 5:18 P.M. and 5:45 P.M., during the dinner meal services, showed Dietary [NAME] W wore gloves and picked up buns with his/her gloved hands. He/She held one side of the bun in his/her hand, placed barbeque pork on the bun with a utensil, then picked up the other side of the bun with his/her gloved hand and placed it on top. He/She opened the utensil drawer with his/her gloved hand, obtained a scoop, closed the drawer and continued to pick up the buns with his/her gloved hands and serve other items from the steam table with utensils.<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 - Many | Observation on 8/5/24 at 5:46 P.M. showed the Dietary Manager took over serving the dinner meal. He/She wore gloves and picked up buns with his/her gloved hands. He/She placed barbeque pork on the bun with a utensil, then picked up the other side of the bun with his/her gloved hand and placed it on top. He/She touched resident meal cards and utensils with his/her gloved hands in between making the sandwiches. During the meal service, the Dietary Manager wore gloves and opened the refrigerator and took a second pan of three-bean salad from the refrigerator. He/She continued serving the meal wearing the same gloves, including handling the bread with his/her gloved hands and touching the meal cards. He/She opened the refrigerator with his/her gloved hand, took out a container of jelly, closed the refrigerator, opened a bag of bread, held the bread in his/her gloved hand, opened the peanut butter container and put peanut butter on the bread with a spatula. He/She placed the spatula with peanut butter on it into the jelly and finished making the sandwich by holding the sandwich in his/her hand.<br><br>3. Review of the facility's undated policy, Sanitizing the Three-Compartment Sink, showed the following:<br><br>-Ensure the sanitizing water is at the appropriate level, is being monitored, documented, and used correctly;<br><br>-Fill the third compartment of the three-compartment sink with water to the line as indicated on the sink;<br><br>-Add premeasured sanitizing solution;<br><br>-Dishes should be submerged in sanitizing solution for 1 to 2 minutes and allowed to air dry.<br><br>Review of the Registered Dietician's Kitchen Observation, dated 7/22/24, showed the three-compartment sink was not properly set up.<br><br>Observation on 8/5/24 at 12:36 P.M. showed the floor under the three-compartment sink and the adjoining counter was heavily soiled with wet and dried food debris. The tiles surrounding the floor drain had been removed and soapy, dirty water from the drain pooled in this area of the floor. The floor drain and the PVC pipe from the sink to the floor drain were heavily soiled. The floor drain grate was rusted with peeling paint. The sanitizer solution bottle, located on the three-compartment sink and connected to the sanitizer hose in the three-compartment sink, was empty. The tube running from the sanitizer to the dispenser was dry.<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 - Many | Observation on 8/5/24 at 2:23 P.M. showed Dietary Aide V washed dishes in the middle compartment of the three-compartment sink. He/She washed two large pans in the dirty water, did not rinse, turned on the sanitizer hose (no sanitizer in the sanitizer solution bottle connected to the sanitizer hose) and wet each pan with the water from the hose, and then put the pans on the dish rack to dry. He/She washed utensils in the dirty water, did not rinse, placed them in the empty sink to his/her left, and quickly sprayed them with water from the sanitizer hose. He/She then placed the six utensils (spoodles and a spatula) on the wet soiled towel on the side of the three-compartment sink. Dietary Staff V then pulled a lever under the middle sink to open the sink drain. As the water drained from the sink, water quickly backed out of the floor drain and onto the floor under the sink. Dietary Aide V closed the drain, waited a couple of seconds, and then opened the drain on the sink again. Water immediately backed out of the floor drain and ran out onto the floor approximately 8 feet under the counter and across the walkway and under a metal shelving unit on the opposite wall. Dry food items were stored on this shelving unit. The water on the floor was dirty with food debris. Dietary Aide V quickly mopped the floor, however, the floor was still soiled with food debris and dirty water.<br><br>During interview on 8/5/24 at 2:25 P.M., the Maintenance Supervisor said the plumbers had been to the facility approximately seven times and said the floor drain was not big enough to handle the water when all three sinks were drained. He was not aware the sink overflowed when only a portion of the water from one sink was drained.<br><br>During interview on 8/5/24 at 2:27 P.M., the Dietary Manager said the sink had been like this since she started working at the facility in May 2024. She directed staff to slowly drain the sink. If water came out of the floor drain, they were to close the sink drain.<br><br>Observation on 8/5/24 at 2:39 P.M. showed the sanitizer solution bottle, located on the three-compartment sink and connected to the sanitizer hose in the three-compartment sink, was empty. The tube running from the sanitizer to the dispenser was dry.<br><br>Observation on 8/5/24 at 3:40 P.M. showed Dietary [NAME] W turned on the water/soap dispenser at the three-compartment sink, ran the water over two pans to wash them in the middle compartment of the three-compartment sink. He/She rinsed the pans under running water but did not sanitize the pans.<br><br>Observation on 8/6/24 at 12:45 P.M. showed the sanitizer bottle, located under the three-compartment sink, remained empty.<br><br>Observation on 8/7/24 at 12:19 P.M. showed Dietary Aide V washed a pan in the middle compartment of the three-compartment sink. The water was dirty and contained very little soap. Dietary Aide V rinsed the pan with water from the sanitizer hose and placed the pan on the drying rack. The sanitizer bottle connected to the sanitizer hose was empty.<br><br>Observation on 8/8/24 at 12:37 P.M., showed washed serving scoops, spoons and a whisk lay on a soiled, wet towel at the end of the three-compartment sink next to the drying rack.<br><br>Observation on 8/8/24 at 2:07 P.M. showed the sanitizer bottle, located under the three-compartment sink, remained empty.<br><br>4. Review of the facility policy, Refrigerator and Freezer Temperatures, dated April 2011, showed the temperature of freezers should be 0 degrees Fahrenheit (F) or below.<br><br>(continued on next page) |

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Observation on 8/5/24 at 11:37 A.M., showed the external thermometer on the three-door freezer showed the internal temperature was 15 degrees F. The internal thermometer showed 20 degrees F. Ice was melting in a small pool of water on the floor of the freezer. A sign was posted on the freezer to keep these doors closed. The freezer contained boxes of frozen food items, including beef and pork.

Observation on 8/5/24 at 2:20 P.M. showed the external thermometer on the three-door freezer showed the internal temperature was 10 degrees F. The internal thermometer showed 15 degrees F. Ice had melted in a pool of water on the floor of the unit.

Observation on 8/6/24 at 11:54 A.M. showed the external thermometer on the three-door freezer showed the internal temperature was 15 degrees F. The internal thermometer showed 28 degrees F.

5. During interviews on 8/5/24 at 2:20 P.M. and on 8/8/24 at 1:30 P.M., the Dietary Manager said the following:

-She went over the RD's report (RD Kitchen Observations) with staff and came up with a method to determine how often staff were to clean and who would be in charge of cleaning these areas;

- The staff were staying on top of cleaning in the kitchen but had not over the last couple of weeks. The deep cleaning was not done like it should due to staffing and illness;

-When she cooked, she cleaned the surfaces thoroughly, but some staff were not doing this;

-The dietary department had a cleaning list that she implemented a couple months ago and posted at the preparation counter, but staff were not following it due to staffing issues.

-Staff were to sweep the floor in the kitchen between meals and mop the floors at the end of the evening shift;

-The three-compartment sink should be set up with a basin for detergent, rinse and sanitizer. Staff should allow items to sit in the sanitizer before drying;

-The two outside sinks in the three-compartment sink do not hold water, so staff are to fill the middle sink with water and detergent, rinse in the left basin and then allow the sanitizer to run in the right basin and let it run over the dishes prior to air drying;

-The three-compartment sink had been like this since she started working in May 2024. She had discussed her concern with the sinks not holding water with the Maintenance Supervisor and the Administrator. They had discussed getting drain stoppers for the basins but she never received any;

-Staff fill the sanitizer buckets with sanitizer from the three-compartment sink. Staff are to keep the washcloths in the sanitizer buckets and to use these washcloths to clean the surfaces.

-There have been problems with the three-door freezer thawing quickly if the doors are open so staff are to get what they need and then close the door quickly. There is a sign on the door to close the door completely. The freezer had been like this since she started in May. She had not told the Maintenance Supervisor or the Administrator about this issue;

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | -Staff were to wash their hands by scrubbing for 20 seconds with soap, dry hands with a paper towel and turn off the sink with the paper towel;<br><br>-If touching food, staff should wear gloves that haven't touched anything else.<br><br>During an interview on 8/22/24 at 3:40 P.M., the Administrator said she was not aware two of the sinks in the three-compartment sink did not drain. She expected staff to clean the kitchen. The Dietary Manager was to address the Registered Dietician's concerns identified during the monthly RD report with the dietary staff. The dietary staff were to follow the cleaning schedules, and the Dietary Manager was to monitor to ensure staff were cleaning per the schedule. |

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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** 32530<br><br>Based on observation, interview, and record review, the facility failed to ensure nursing staff performed appropriate hand hygiene and changed gloves during the provision of care for two additional residents (Residents #32 and #2), and four residents (Residents #23, #22, #43, and #47), in a review of 18 sampled residents. The facility failed to implement Enhanced Barrier Precautions for one resident (Resident #19), and failed to complete Tuberculin Skin Testing to rule out Tuberculosis (TB) for three employees, in a review of 10 sampled employees. The facility census was 82.<br><br>Review of the facility policy, Hand Hygiene and Gloves, dated August 2009, showed the following:<br><br>-Wash hands with soap and water when hands are visibly dirty or soiled with blood or other body fluids, or after using the restroom;<br><br>-Clean your hands by rubbing them with an alcohol based formulation if your hands are not visibly soiled;<br><br>-Use hand hygiene before touching a resident, before clean/aseptic procedure, after body fluid exposure risk, after touching a resident, after touching a resident's surroundings;<br><br>-Gloves must be worn according to standard and contact precautions;<br><br>-The use of gloves does not replace the need for washing your hands;<br><br>-Remove gloves to perform hand hygiene when an indication occurs while wearing gloves;<br><br>-Discard gloves after each task and clean your hands.<br><br>Review of Infection Control Guidelines for Long-Term Care Facilities emphasis on Body Substance Precautions, dated January 2005, showed the following:<br><br>-Handwashing remains the single most effective means of preventing disease transmission;<br><br>-Wash hands often and well, paying particular attention to around and under fingernails and between the fingers;<br><br>-Wash hands whenever they are soiled with body substances, before food preparation, before eating, after using the toilet, before performing invasive procedures and when each resident's care is completed;<br><br>-Gloves must be changed between residents and between contacts with different body sites of the same resident.<br><br>1. Review of Resident #32's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 6/12/24, showed the following:<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 | -Cognition was intact;<br><br>-Occasionally incontinent of bowel and bladder;<br><br>-Partial assistance with toileting and personal hygiene.<br><br>Review of the resident's care plan, dated 7/20/24, showed staff was to provide peri area cleansing following any incontinence episodes.<br><br>Observation on 8/7/24 at 5:04 A.M. showed the following:<br><br>-Without washing hands with soap and water or using hand sanitizer, Certified Nurse Assistant (CNA) A put on gloves and a gown, entered the resident's room and prepared supplies;<br><br>-The resident lay in bed and was incontinent of bowel;<br><br>-CNA A removed the resident's feces soiled incontinence brief and cleaned the resident's perineum (the area between the genitals and the rectal opening) with incontinent wipes, then rolled the soiled disposable bed pad under the resident;<br><br>-Without removing his/her gloves, CNA A rolled a clean bed pad and clean incontinence brief under the resident, rolled the resident to his/her right side, and removed the soiled bed bed. CNA A then tucked and pulled a clean bed pad and incontinence brief under resident;<br><br>-With the same gloves he/she wore to provide incontinence care, CNA A grabbed a tube of barrier cream from the resident's bedside table, applied barrier cream to the resident's buttocks, pulled up the resident's blanket, placed a pillow between residents knees, and assisted the resident with a drink of water by touching the cup and taking it to the resident's mouth;<br><br>-CNA A picked up a trash bag, and without removing his/her gloves, handed the resident his/her phone, left the room, threw the trash away and then removed his/her gloves;<br><br>-CNA A did not wash hands with soap and water after doffing gloves.<br><br>During interviews on 8/7/24 at 6:10 A.M. and 8/19/24 at 12:40 P.M., CNA A said the following:<br><br>-Staff should wash hands before, during and after providing care to a resident;<br><br>-Staff should change gloves and wash hands when moving from dirty to clean objects;<br><br>-Staff should wash hands/ use hand sanitizer between changing gloves.<br><br>-He/She should have changed gloves and washed hands after providing pericare and before touching clean items and offering the resident a drink.<br><br>2. Review of Resident #23's significant change MDS, dated [DATE], showed the following:<br><br>-Severe cognitive impairment;<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 | -Moderate assistance with toileting hygiene and personal hygiene;<br><br>-Incontinent of bowel and bladder.<br><br>Review of the resident's Care Plan, dated 6/16/24, showed the following:<br><br>-Provide assistance of one staff with dressing and grooming hygiene;<br><br>-Provide peri-area cleansing following any incontinence episodes.<br><br>Observation on 8/7/24 at 5:45 A.M. showed the following:<br><br>-Without washing hands with soap and water or using hand sanitizer, CNA A donned gloves, cleaned the resident's perineum with wipes and removed feces from the resident's skin;<br><br>-CNA A placed the soiled wipes in the trash bag and rolled the soiled incontinence brief and bed pad under the resident;<br><br>-Without removing his/her gloves, CNA A rolled a clean incontinence brief and clean bed pad under resident, touched the resident's leg and assisted him/her to roll to his/her other side;<br><br>-Wearing the same gloves he/she wore to provide incontinence care, CNA A removed the soiled incontinence brief and bed pad, and pulled the clean incontinence brief and bed pad from under the resident, fastened the incontinence brief, and covered the resident with the sheet;<br><br>-CNA A took the trash and linens to the hallway, removed his/her gloves and used hand sanitizer.<br><br>During an interview on 8/7/24 at 6:10 A.M. and 8/19/24 at 12:40 P.M., CNA A said the following:<br><br>-Staff should wash hands before, during and after providing care to a resident;<br><br>-Staff should change gloves and wash hands when moving from dirty to clean objects;<br><br>-Staff should wash hands/ use hand sanitizer between changing gloves.<br><br>3. Review of Resident #2's quarterly MDS, dated [DATE], showed the following:<br><br>-Severe cognitive impairment;<br><br>-Required substantial to maximal assistance with toileting hygiene;<br><br>-Frequently incontinent of bowel and bladder.<br><br>Review of the resident's care plan, dated 6/19/24, showed the following:<br><br>-Assess grooming and dressing needs and provide assistance from one staff;<br><br>-Provide peri-area cleansing following any incontinence episodes.<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 8/7/24 at 5:15 A.M. showed the following;<br><br>-CNA B put on gloves outside the resident room without washing hands with soap and water or using hand sanitizer and entered the resident's room ;<br><br>-CNA B rolled the resident to his/her left side, cleaned urine from the resident's groin, genital area and buttocks;<br><br>-Without removing his/her gloves, he/she tucked a clean incontinence brief under the resident, rolled the resident on his/her back, touching the resident on his/her right shoulder and right hip, and fastened the resident's clean incontinence brief;<br><br>-Wearing the same gloves he/she wore to provide incontinence care, CNA B picked up a stack of clean incontinence briefs from the resident's bedside dresser, took them outside the room, placed them on a shelf in the hallway, for other staff and residents to use, and removed his/her gloves;<br><br>-CNA B returned to the resident's room, and without washing hands with soap and water, put on gloves, assisted the resident to put on a gown, removed the soiled sheet and blanket and covered the resident with a clean sheet and blanket;<br><br>-CNA B removed the trash from the resident's room, took the trash to the hallway and removed his/her gloves;<br><br>-CNA B put on new gloves, returned to the resident's room to get dirty linens, took the dirty linens to a laundry hamper in the hall, removed his/her gloves and used hand sanitizer.<br><br>During an interview on 8/7/24 at 6:13 A.M. and 8/19/24 at 6:50 A.M., CNA B said the following:<br><br>-He/She should have changed gloves from dirty to clean;<br><br>-He/She did not think to have hand sanitizer or extra gloves with him/her.<br><br>-Staff should change gloves, use hand hygiene between glove changes when moving from dirty to clean objects;<br><br>-Staff should wash hands before, during and after care of a resident;<br><br>-Staff should wash hands or use hand sanitizer between changing gloves.<br><br>4. Review of Resident #22's quarterly MDS, dated [DATE], showed the following:<br><br>-Cognition was intact;<br><br>-Continent of bowel and bladder.<br><br>Review of the resident's Care Plan, last revised on 05/10/24, showed the following:<br><br>-The resident's diagnoses included incontinence;<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 | -The resident required staff to provide toileting assistance to promote bowel and bladder function.<br><br>Observation on 08/06/24 at 5:06 A.M. showed the following:<br><br>-The resident was incontinent and soiled with urine;<br><br>-While wearing gloves, Nurse Assistant (NA) U cleaned urine from the resident's perineal area;<br><br>-NA U did not remove his/her gloves after he/she completed cleaning the resident;<br><br>-While wearing the same soiled gloves he/she touched the resident's clean incontinence brief and clean pants, blanket, and the closet door handle;<br><br>-NA U then removed his/her gloves, exited the room without washing and/or sanitizing his/her hands, walked down the hall, and entered another resident's room.<br><br>During an interview on 08/07/24 at 5:45 P.M., NA U said the following:<br><br>-He/She was supposed to wash his/her hands upon entering a resident's room, between glove changes, and before exiting the room;<br><br>-He/She should not touch clean surfaces with contaminated gloves and hands;<br><br>-He/She did not change or remove his/her gloves and/or wash/sanitize his/her hands because he/she just didn't think about it.<br><br>5. Review of Resident #43's quarterly MDS, dated [DATE], showed the following:<br><br>-Required substantial to maximum assistance with personal hygiene;<br><br>-Frequently incontinent of bladder and bowel.<br><br>Review of the resident's Care Plan, last revised 7/20/24 showed the following:<br><br>-Incontinence;<br><br>-Perform incontinence care per episode.<br><br>Observation on 8/7/24 at 4:30 A.M. showed the following:<br><br>-The resident lay on his/her left side in bed and was soiled with urine and feces;<br><br>-NA X wiped feces from the resident's anal area;<br><br>-NA X did not removed his/her gloves, and touched the resident's knee to assist the resident to roll to the right side and applied barrier cream to the resident's buttocks;<br><br>(continued on next page) |

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| | 265160 | A. Building<br>B. Wing | 08/08/2024 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -NA X removed the urine soiled incontinence brief from under the resident and laid it on the linens at the end of the bed;<br><br>-While wearing the same gloves he/she wore to provide incontinence care, NA X placed a clean incontinence brief on the resident;<br><br>-NA X placed the urine soiled incontinence brief in the trash can, did not remove his/her gloves, then lowered the bed, placed a pillow between the resident's right arm and the assist rail, and covered the resident with the sheet;<br><br>-NA X removed his/her gloves, did not wash his/her hands, exited the room, opened a cabinet in the hallway, obtained trash bags and re-entered the room;<br><br>-NA X gathered the trash, picked up a soiled bed linen, and without bagging the linen, walked out of the room, placed the trash in the garbage, walked around the nurse's desk and placed the linen in the laundry hamper and then walked to the kitchenette to wash his/her hands.<br><br>During an interview on 8/16/24 at 8:30 A.M., NA X said the following:<br><br>-He/She should change his/her gloves when they become soiled;<br><br>-He/She should wash his/her hands before cares, when he/she changed his/her gloves, and before touching any clean surfaces after providing perineal care;<br><br>-He/She should remove his/her soiled gloves and wash his/her hands before exiting a room.<br><br>6. Review of Resident #47's quarterly MDS, dated [DATE], showed he/she was always incontinent of bladder and bowel.<br><br>Review of the resident's Care Plan, last revised 6/9/24, showed the following:<br><br>-Urinary incontinence;<br><br>-Provide peri-area cleaning following any incontinent episodes. May use barrier cream as needed.<br><br>Observation on 8/7/24 at 5:19 A.M. showed the following:<br><br>-The resident lay on his/her back in the bed;<br><br>-NA U entered the room, and without washing his/her hands, put on gloves, and pulled the blankets off of the resident;<br><br>-He/She cleaned urine from the resident's front perineal area;<br><br>-While wearing the same gloves, he/she assisted the resident to his/her left side;<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 | -NA U cleaned the resident's backside, and without removing his/her gloves and washing his/her hands, NA U tucked a clean incontinence brief under the resident, assisted the resident to roll back, fastened the brief in place, placed a pillow under the resident's left arm, and covered the resident;<br><br>-He/She removed the gloves, and without washing his/her hands, put on clean gloves and carried the trash out of the room.<br><br>7. Review of the facility policy, Enhanced Barrier Precautions (EBP) to Infection Control Guidance, dated March 2024, showed the following:<br><br>-The purpose of the policy is to prevent broader transmission of MDRO (multidrug-resistance organisms) and to help protect patients with chronic wounds and indwelling devices. EBP (Enhanced barrier precautions) should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed.<br><br>-Who requires EBP:<br><br>-Residents known to be infected or colonized with a MDRO<br><br>-Residents with an indwelling medical device including the following: Central venous catheter, urinary catheter, feeding tube (PEG tube, G-tube), tracheostomy/ventilator regardless of their MDRO status<br><br>-Residents with a wound, regardless of their MDRO status<br><br>-Use EBP when providing high- contact resident care activities such as those listed below.<br><br>-Bathing/showering<br><br>-Transferring residents from one position to another<br><br>-Providing hygiene<br><br>-Changing bed linens<br><br>-Changing briefs or assisting with toileting<br><br>-Caring for or using an indwelling medical device<br><br>-Performing wound care<br><br>-Gloves and donning and doffing of gown are required when conducting high-contact resident care activities that are listed above. Gloves and gown should be removed and discarded after each resident care encounter.<br><br>8. Review of Resident #19's care plan, dated 6/24/24, showed the following:<br><br>-The resident had a urinary catheter due to urinary retention;<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 | -Staff were instructed to empty the resident's catheter drainage bag contents every shift and as needed.<br><br>(The resident's care plan did not identify the resident was on enhanced barrier precautions.)<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the following:<br><br>-Cognitively intact;<br><br>-Urinary catheter;<br><br>-Dependent on staff for bathing.<br><br>Review of the resident's Physician's Orders, dated July 2024, showed the resident had a catheter. Staff were to provide catheter care every shift.<br><br>Observation on 8/7/24 at 10:32 A.M. showed PPE, including gowns, hung in an organizer on the resident's room door. The resident sat on the side of his/her bed. The resident's urinary catheter bag was attached to the resident's walker at his/her bedside. The resident said he/she had just had a shower.<br><br>During interview on 8/7/24 at 10:36 A.M., CNA R said he/she was the aide assigned to the resident's hall. He/She gave the resident a shower this morning. He/She did not wear a gown when he/she gave the resident a shower and did not wear a gown when taking care of the resident's catheter. He/She said the PPE was on the resident's room door when he/she started working at the facility in June. No one told him/her what the PPE was for. He/She did not know why the PPE was on the resident's room door or which resident it was for (the resident or his/her roommate).<br><br>During an interview on 8/7/24 at 11:20 A.M., the resident's family member said staff do not wear a gown when they provide care for the resident.<br><br>During interview on 8/7/24 at 11:22 A.M., the resident said staff do not wear a gown when they care for his/her catheter.<br><br>During an interview on 08/07/24 at 5:30 A.M., NA U said the following:<br><br>-He/She was unsure why PPE was on the back of the residents' doors;<br><br>-Residents who had COVID were on a separate unit and none of these residents had COVID;<br><br>-He/She was not aware of what EBP was;<br><br>-He/She thought maybe the PPE was on the door because these residents had an infectious disease process;<br><br>-Signs on the door did not direct which resident was on precautions; he/she just had to guess which one was under precautions;<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 | -He/She did not receive any information from the previous shift;<br><br>-He/She should wear the PPE if was on the door, but he/she did not.<br><br>9. During an interview on 08/21/24 at 2:30 P.M., the Director of Nursing said the following:<br><br>-Staff were to wash and/or sanitize their hands before care, in between glove changes, and following care of the resident;<br><br>-Staff should not touch any clean surfaces with contaminated gloves and/or hands;<br><br>-She expected staff to follow EBP as listed on the resident's doors;<br><br>-Residents who required EBP included those with a catheter, open wounds, and or any other implanted invasive device;<br><br>-She expected staff to wear PPE as indicated on the resident's door when providing personal care.<br><br>10. Review of the facility's undated policy, Guidelines for Screening for Tuberculosis in Long-Term Care Facilities, Recommendations for Employees, showed the following:<br><br>-Provide a tuberculin skin test (TST) to all employees during pre-employment procedures.<br><br>-If the initial skin test result is 0-9 milliliters (mm), a second test should be given at least one week and no more than three weeks after the first test.<br><br>-The results of the second test should be used as the baseline in determining treatment and follow-up of these employees.<br><br>11. Review of the Activity Director's employee file showed the following:<br><br>-Her start date was 7/8/24;<br><br>-She received the first-step TST on 7/5/24, and staff read the results on 7/8/24;<br><br>-No documentation staff administered the second-step TST.<br><br>12. Review of Licensed Practical Nurse (LPN) P's employee file showed the following:<br><br>-His/Her start date was 7/23/24;<br><br>-No documentation he/she received the first-step TST.<br><br>13. Review of Housekeep Q's employee file showed the following:<br><br>-His/Her start date was 5/23/24;<br><br>-He/She received the first-step TST on 5/21/24, and staff read the results on 5/23/24;<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 | -No documentation staff administered the second-step TST.<br><br>During an interview 8/8/24 at 12:10 P.M., the Director of Nursing said the following:<br><br>-The Staffing Coordinator was responsible for employee TB testing; the Staffing Coordinator was no longer employed at the facility as of 8/1/24;<br><br>-Staff were to administer the first-step TST when the new employee accepted the position (prior to hire);<br><br>-Staff read the results of the first-step TST on the employee's start date;<br><br>-Staff were to administer the second step TST seven to 21 days after the first-step TST;<br><br>-She had not audited the employee TB testing for a while.<br><br>32899<br><br>45563 |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530<br><br>Based on interview and record review, the facility failed to provide the pneumococcal vaccine (a vaccine that can protect against pneumococcal disease) as indicated by the current Centers for Disease Control and Prevention (CDC) guidelines for five residents (Residents #23, #78, #3, #19, and #45), in a review of 18 sampled residents. The facility census was 82.<br><br>Review of the facility's undated policy, Immunization, showed the following:<br><br>-The resident's physician will be consulted and determine the level of risk and need for the vaccinations;<br><br>-A physician order is required to administer any vaccination;<br><br>-The resident/or responsible party have been educated/given a copy of The Center for Disease Control Vaccine Information Sheet on pneumococcal vaccines and have had the immunization consent. or refusal form filled out and signed by resident/ or responsible party.<br><br>Review of the CDC Pneumococcal Vaccination: Summary of Who and When to Vaccinate, reviewed 9/22/23, showed the following:<br><br>-Adults [AGE] years or older who have never received any pneumococcal vaccine and don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak:<br><br>1. Give one dose of PCV15 or PCV20;<br><br>2. When PCV15 is used, it should be followed by a dose of PPSV23 at least one year later. Their vaccines will then be complete;<br><br>3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. The vaccines are then complete;<br><br>-Adults [AGE] years or older who have never received any pneumococcal vaccine and have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak:<br><br>1. Give one dose of PCV15 or PCV20;<br><br>2. When PCV15 is used, it should be followed by a dose of PPSV23 at least 8 weeks later. Their vaccines will then be complete;<br><br>3. When PCV20 is used, it does not need to be followed by a dose of PPSV23. Their vaccines are then complete.<br><br>-Adults [AGE] years or older who have only received the PPSV23 regardless of risk condition;<br><br>1. Give one dose of PCV15 or PCV20 at least one year after the most recent PPSV23 vaccination;<br><br>(continued on next page) |

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F 0883

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they have already received it. Their vaccines are then complete.

-Adult [AGE] years or older who have only received the PCV13 and don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak;

1. Give one dose of PCV 20 or PPSV23, at least 1 year after PCV13. Regardless of vaccine used, their vaccines are then complete.

-Adults [AGE] years or older who have only received the PCV13 and have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak;

1. Give one dose of PCV20 or PPSV23. Regardless of vaccine used, their vaccines are then complete;

2. The PCV20 dose should be given at least 1 year after PCV13.

3. The PPSV23 dose should be given at least 8 weeks after PCV13.

-Adults [AGE] years and older who have received PCV13 at any age and PPSV23 before age 65 and don't have an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak;

1. Give one dose of PCV20 of PPSV23. Regardless of vaccine used, their vaccines are then complete.

2. The PCV20 dose should be given at least 5 years after the last pneumococcal vaccine;

3. The PPSV23 dose should be given at least 5 years after the last PPSV23 dose. It should also be given at least 1 year after the PCV13 dose.

-Adults [AGE] years and older who have received PCV13 at any age and PPSV23 before age 65 who have an immunocompromising condition, cochlear implant or cerebrospinal fluid leak;

1. Give 1 dose of PCV20 or PPSV23. Regardless of vaccine used their vaccines are then complete;

2. The PCV20 dose should be given at least 5 years after the last pneumococcal vaccine;

3. The PPSV23 dose should be given at least 5 years after the last PPSV23 dose. It should also be given at least 8 weeks after the PCV13 dose.

-Adults [AGE] years or older who have received the PCV13 at any age and the PPSV23 after the age of 65;

1. Use shared clinical decision-making to decide whether to administer PCV20.

2. If so, the dose of PCV20 should be administered at least five years after the last pneumococcal vaccine.

-Adult [AGE] years or older who have only received PPSV23:

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265160 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/08/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Lewis & Clark Gardens | | STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Boones Lick Road Saint Charles, MO 63301 | |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1. Give 1 dose of PCV15 or PCV20 at least 1 year after the most recent PPSV23 vaccination;<br><br>2. Regardless of vaccine given, an additional dose of PPSV23 is not recommended since they already received it. Their vaccines are then complete.<br><br>1. Review of Resident #23's medical record showed the following:<br><br>-The resident received the PPSV23 on 1/21/13 (when over the age of 65);<br><br>-The resident received the PCV13 on 4/18/17 (when over the age of 65).<br><br>Review of the resident's face sheet showed the following:<br><br>-admitted [DATE];<br><br>-The resident had a power of attorney (POA);<br><br>-Diagnoses included COVID-19 (an infectious disease that can affect the upper and lower respiratory tract), pneumonia (lung infection caused by bacteria, fungi, and viruses), disorder of the renal gland and hypertensive chronic kidney disease (condition where high blood pressure causes kidney damage);<br><br>-The resident was over [AGE] years of age.<br><br>Review of the resident's Immunization Consent or Refusal Form, dated 06/07/22, showed the resident marked his/her initials in the box for PCV20, indicating he/she consented to receiving the vaccination.<br><br>Review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument, dated 6/6/24, showed the resident's pneumococcal vaccine was up to date.<br><br>Review of the resident's medical record showed the following:<br><br>-No documentation the resident received the PCV20 vaccination;<br><br>-No documentation to show any clinical decision-making was made (per CDC guidelines) or that the resident/POA refused a PCV20 vaccine for the resident's pneumococcal vaccination to be complete.<br><br>During an interview on 8/14/24 at 8:25 A.M., the resident's POA said the following:<br><br>-The resident was not offered an updated pneumonia vaccine;<br><br>-He/She wanted the resident to have the updated pneumonia vaccine.<br><br>2. Review of Resident #78's medical record showed he/she received the PPSV23 on 9/10/20.<br><br>Review of the resident's face sheet showed the following:<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Lewis & Clark Gardens | | STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Boones Lick Road Saint Charles, MO 63301 | |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -admitted [DATE];<br><br>-The resident had a POA;<br><br>-Diagnoses included COVID-19;<br><br>-The resident was over [AGE] years of age.<br><br>Review of the resident's admission MDS, dated [DATE], showed the following:<br><br>-The resident's pneumococcal vaccine section was blank;<br><br>-The resident was not offered the pneumococcal vaccine.<br><br>Review of the resident's medical record showed the following:<br><br>-The resident was not up to date on the pneumococcal vaccination per CDC recommendations;<br><br>-No documentation to show the resident received one dose of PCV15 or PCV20 for the resident's pneumococcal vaccination to be complete.<br><br>During an interview on 8/13/24 at 1:10 P.M., the resident's POA said the following:<br><br>-The resident was not offered an updated pneumonia vaccine;<br><br>-He/She wanted the resident to have the updated pneumonia vaccine.<br><br>3. Review of Resident #3's medical record showed he/she received the PPSV23 on 1/11/19.<br><br>Review of the resident's Continuity of Care Document showed the following:<br><br>-admitted [DATE];<br><br>-The resident had a responsible party to help with decision making;<br><br>-Diagnoses included COVID-19 and pneumonia (unspecified cause);<br><br>-The resident was over [AGE] years of age.<br><br>Review of the resident's Vaccination Consent Form, signed and dated 10/3/23, showed the resident wanted to receive the PCV20.<br><br>Review of the resident's admission MDS, dated [DATE], showed the following:<br><br>-Intact cognition;<br><br>-The resident's pneumococcal vaccine was up to date.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Lewis & Clark Gardens | | STREET ADDRESS, CITY, STATE, ZIP CODE 1221 Boones Lick Road Saint Charles, MO 63301 | |

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| F 0883<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 no evidence the resident received any pneumococcal vaccines after his/her admission on 10/3/23.<br><br>During an interview on 8/5/24 at 4:00 P.M., the resident said he/she believed his/her vaccines were up to date but was unsure as his/her family handled all of that for him/her.<br><br>4. Review of Resident #19's Continuity of Care Document showed the following:<br><br>-He/She was admitted on [DATE];<br><br>-He/She was over [AGE] years of age;<br><br>-His/He diagnoses included high blood pressure and heart disease.<br><br>Review of the resident's Immunization Consent, dated 12/22/23, showed the resident provided consent to receive the pneumococcal vaccination.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident's pneumococcal vaccination was not up to date.<br><br>Review of the resident's Immunization Record showed no documentation the resident received a pneumococcal vaccination after he/she gave consent on 12/22/23.<br><br>5. Review of Resident #45's Continuity of Care Document showed the following:<br><br>-He/She was admitted on [DATE];<br><br>-He/She was over [AGE] years of age;<br><br>-His/Her diagnoses included high blood pressure.<br><br>Review of the resident's Immunization Consent, dated 3/20/24, showed the resident provided consent to receive the pneumococcal vaccination.<br><br>Review of the resident's quarterly MDS, dated [DATE], showed the resident's pneumococcal vaccination was not up to date.<br><br>Review of the resident's Immunization Record showed no documentation the resident received a pneumococcal vaccination after he/she gave consent on 3/20/24.<br><br>6. During an interview on 08/21/24 at 2:30 P.M., the Director of Nursing (DON) said the following:<br><br>-The facility should offer and administer the pneumococcal vaccinations per CDC guidelines;<br><br>-The Assistant Director of Nursing (ADON) was responsible for ensuring immunizations were up to date;<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -She was aware some pneumococcal vaccinations were not current and was working with the ADON to ensure residents received immunizations and were up to date.<br><br>During an interview on 8/23/24 at 12:33 P.M., the ADON said the following:<br><br>-He/She was responsible for administering the pneumonia vaccinations;<br><br>-He/She followed the CDC guidelines;<br><br>-He/She checked resident's history for receiving the pneumonia vaccine through the state's immunization information system, from transferred facilities, hospital records, and physician offices:<br><br>-He/She would follow the PPSV23 with the PCV20 if it was due;<br><br>-Once a consent was signed that a resident wanted the PCV20, it should have been administered as soon as possible. |