STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265166	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, St Charles	35 Sugar Maple Lane Saint Charles, MO 63303

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32530 Based on observation, interview, and record review, the facility failed to safely transfer one resident (Resident #36), in a review of 21 sampled residents, during a mechanical lift transfer when staff failed to maintain control of the resident during the transfer, causing the resident to hit his/her head and foot on the lift. The facility census was 89. 1. Review of Resident #36's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 5/23/24, showed the following: -His/Her cognition was moderately impaired; -Dependent on staff for bed to chair transfers and chair to bed transfers. Review of the resident's care plan, last reviewed/updated on 5/28/24, showed he/she required the use of a mechanical lift for all transfers. Review of the certified nurse assistant (CNA) care reference book, located at the nurse's desk, showed the resident required two persons assist with the mechanical lift. Observation on 6/19/24 at 10:42 A.M. showed the following: -The resident lay in his/her bed; -CNA A and CNA B placed a lift pad under the resident to transfer him/her from the bed to the shower gurney; -CNA B operated the lift moving the resident from the bed to the shower gurney; the sides of the shower gurney were in the raised position and CNA A and CNA B were not able to get the resident on the gurney; -CNA C did not to keep his/her hands on the resident as the resident swung in mid air; -As the resident was next to the gurney, CNA C placed his/her hands on the resident to move the resident away from the gurney to lower the side rail on the gurney. When the CNA moved the resident away from the gurney, the resident hit the back of his/her head on the lift. The resident said, ouch. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 6/19/24 at 11:45 A.M. showed the following: -The resident returned to his/her room from the shower via a shower gurney; -CNA B and CNA C placed the lift pad under the resident to transfer him/her from the shower gurney to his/her wheelchair; -CNA C operated the lift while CNA B prepared the wheelchair; -CNA C used the mechanical lift to raise the resident from the shower gurney and pushed the lift with the resident swinging in mid air from the gurney to the wheelchair. No staff guided the resident while he/she was in the lift. -While the resident swung in midair, he/she spun around and hit his/her right foot on the lift. The resident said, ouch. During an interview on 6/19/24 at 1:45 P.M., the resident said the following: -Sometimes the staff rush and the mechanical lift transfers were kind of rough; -He/She hit his/her head and foot on the lift today when the staff were getting him/her up. During an interview on 6/19/24 at 2:10 P.M., CNA B said the following: -Mechanical lift transfers required two staff; -One staff should always hold and maintain control of the resident; -Residents should not be left hanging in midair; -They did not have control of the resident, and the resident hit his/her head and foot on the lift during the transfer; -There were only two staff on the very heavy hall (residents who resided on the call required a lot of care) and they were rushed to get the transfer done; -The resident should not have hit his/her head and foot on the lift. During an interview on 6/19/24 at 2:30 P.M., CNA C said the following: -Mechanical lift transfers required two staff; -One staff should always hold and maintain control of the resident; -Residents should not be left hanging in midair; -They did not have control of the resident and the resident hit his/her head and foot on the lift during the transfer; (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There were only two staff on the very heavy hall and they were rushed to get the transfer done. During an interview on 6/20/24 at 2:32 P.M., the Director of Nursing said she expected staff to maintain control of a resident during a mechanical lift transfer. A resident should not have been left hanging in midair without staff maintaining control. The resident should not have hit their head and/or foot on the lift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49528 Based on observation, interview and record review, the facility failed to ensure nursing staff performed appropriate hand hygiene and changed gloves during personal care of two residents (Residents #21 and #55), in a review of 21 sampled residents. The facility census was 89. Review of the facility's policy, Hand Hygiene, dated April 2024, showed the following: -Hand hygiene includes both handwashing with plain or antiseptic containing soap and water or the use of alcohol-based products that do not require the use of water for the following situations: -Before and after contact with each resident; -Before donning gloves; -After removing gloves. Review of the facility's policy, Glove Technique, dated April 2024, showed gloves are used to prevent contamination of healthcare personnel hands in the following situations: -Anticipating direct contact with blood or body fluids, mucous membranes, nonintact skin and other potentially infectious material; -Having direct contact with residents who are colonized or infected with pathogens transmitted by the contact route; -Handling or touching visibly or potentially contaminated resident care equipment and environmental surfaces. 1. Review of Resident #21's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, dated 5/31/24, showed the following: -Dependent on staff for toilet hygiene and transfers; -Always incontinent of bowel and bladder. Observation on 6/17/24 at 1:30 P.M. showed the following: -Certified Nurse Assistant (CNA) G entered the resident's room, and without washing his/her hands, put on gloves; -CNA G assisted the resident to the bathroom with the sit-to-stand lift; -CNA G removed the resident's soiled incontinence brief and assisted the resident to sit on the toilet; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA G removed his/her gloves, did not wash his/her hands, and put on new gloves. He/She went to the resident's roommate's closet to get out clothes for the roommate's shower to be done after this resident was done toileting; -CNA G returned to the bathroom and removed the resident's soiled pants, and while wearing the same gloves, he/she put clean pants and a clean incontinence brief on the resident, raised the resident off the toilet with the sit-to-stand lift and used incontinence wipes to provide incontinence care. He/She grabbed more wipes with the same gloved hand as he/she had provided incontinence care; -Without changing his/her gloves after providing incontinence care, CNA G pulled up resident's incontinence brief and pants and lowered the resident into a wheelchair; -CNA G wiped fecal matter off the toilet, removed one glove, picked up the trash with the other gloved hand, and left the resident's room and take the trash to the trash bin in the closet on the hall. Observation on 6/19/24 at 7:04 A.M. showed the following: -CNA G entered the resident's room, and without washing his/her hands, put on gloves; -The resident lay in bed and his/her incontinence brief was soiled with urine; -CNA G attached the sling for the sit-to-stand lift, raised the resident to a standing position, removed the wet incontinence brief and cleaned the resident's peri area with incontinence wipes; -Without removing his/her gloves, CNA G pulled up the resident's clean incontinence brief and pants, lowered the resident into a wheelchair with the sit-to-stand lift, removed the sling for the sit-to-stand lift from around the resident, assisted the resident to put on his/her shirt, and gave the resident a wet washcloth to wash his/her face; -CNA G stripped the linens off the bed, removed the trash and took it to the utility room closet on the resident's hall; -CNA G then removed his/her soiled gloves and used hand sanitizer. During an interview on 6/19/24 at 10:15 A.M., CNA G said he/she should change his/her gloves between dirty and clean cares. 2. Review of Resident #55's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -He/She required maximum assistance with toileting; -He/She was always incontinent of bowel and bladder. Review of the resident's care plan, updated 4/15/24, showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She needed assistance in performing, improving and maintaining some activities of daily living (ADLs); -He/She was incontinent of bowel and bladder. Observation on 6/19/24 at 10:53 P.M. showed the following: -CNA C wore gloves and removed the resident's urine-soiled incontinence brief; -Without removing his/her gloves, CNA C assisted the resident to put on clothing, rolled the resident to his/her side and wiped the resident's back and buttock; -CNA C did not remove his/her gloves, put the mechanical lift pad and a clean incontinence brief under the resident, rolled the resident to his/her back and provided incontinence care; -CNA C did not remove his/her gloves after providing incontinence care and finished dressing the resident; -CNA C removed his/her gloves and did not wash hands; -CNA C and Certified Occupational Therapist Assistant (COTA) used the mechanical lift to transfer the resident from the bed to the chair; -CNA C took the resident in his/her chair into the hall, brushed the resident's hair, put glasses on the resident's face, and put shoes on the resident's feet. During an interview on 6/19/24 at 2:18 P.M., CNA C said the following: -He/She should change his/her gloves after providing peri-care; -He/She should wash his/her hands after taking dirty gloves off and putting on clean gloves; -He/She should change his/her gloves when going from a dirty area to a clean area; -He/She was in a hurry when performing the resident's care and that was why he/she did not change his/her gloves. During an interview on 6/20/24 at 2:32 P.M., the Director of Nursing (DON) said the following; -Staff should perform hand hygiene after removing dirty gloves and before putting on clean gloves; -When performing incontinence care, staff were to change their gloves between dirty and clean areas; -Staff should wash their hands or use hand sanitizer after removing dirty gloves and before putting on clean gloves; -If gloves were soiled, the staff should not touch anything and wash hands after removing gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should not touch any clean items with contaminated gloves and/or hands. 50189 50851

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32530 Based on observation, interview, and record review, the facility failed to complete inspections of bed frames, mattresses, and bed rails, as part of a regular maintenance program to identify areas of possible entrapment for three residents (Resident #3, #7, #36), who used bed rails/assist bars, in a review of 21 sampled residents. The facility census was 89. Review of the undated facility policy, Bed Rails Safety Check, showed the following: -When using bed rails, close attention must be given to the design of the rail and the relationship between rails and other parts of the bed. The seven areas in the bed system that have the potential for entrapment include; 1. Within the rail; 2. Under rail, between rail supports; 3. Between rail and mattress; 4. Under rail, and ends of rail; 5. Between split bed rails; 6. Between end of rail and side edge of head or foot board; 7. Between head or foot board and mattress end; -Entrapment may occur in flat or raised bed positions, with the rails fully or partially raised; -Regularly inspect each of the seven areas on each bed; -The mattress to bed rail interface should prevent an individual from falling between the mattress and bed rails and possibly smothering; -Check for compression of the mattress's outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail; -Ensure that the mattress is appropriately sized for the bed frame. Not all beds and mattresses are interchangeable; -The space between the bed rails and the mattress and the headboard and the mattress should be filled by the mattress or by an added firm inlay. This creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails; -Bed rails with tapered or winged ends should not be used for residents at risk of entrapment; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Maintenance and monitoring of the bed, mattress, and accessories should be ongoing; -Summary of Federal Drug Administration (FDA) potential zones of entrapment with FDA dimension recommendations; 1. Zone 1: Within the rail, FDA recommended space is: less than 4 3/4 inches; 2. Zone 2: Under the rail between rail supports or next single rail support, FDA recommended is less than 4 3/4 inches; 3. Zone 3: Between the rail and the mattress, FDA recommended space is less than 4 3/4 inches; 4. Zone 4: Under the rail at the ends of the rail, FDA recommended space is less than 2 3/8 inches and greater than 60-degree angle. 1. Review of Resident #3's physician order sheet (POS), dated June 2024, showed an open-ended order for quarter side rails for positioning and bed mobility (original order dated 10/11/23). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility, dated 6/4/24, showed the following: -The resident had moderately impaired cognition; -He/She had impairment with range of motion (ROM) with one side of both upper and lower extremities; -He/She was independent with rolling right and left in bed; -He/She was independent with lying to sitting on the side of bed. Review of the resident's quarterly bed rail assessment, dated 6/4/24, showed the following: -Type of rail used: right side bed cane; -He/She demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed; -There was no documentation of entrapment zone measurements. Review of the resident's care plan, last reviewed/updated 6/5/24, showed the following: -Left side cane rail (assist rail) to assist with transfers; -Assist of one staff for transfers; -Independent with bed mobility. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/18/24 at 2:48 P.M., showed the following: -The resident lay in his/her bed with his/her feet hanging off the right side of the bed; -An assist rail was attached to the right side of the resident's bed and was in the raised position; -The mattress did not fit appropriately and there was a gap between the mattress and the assist rail, exposing the metal bed frame. Observation on 06/19/24 at 5:45 A.M., showed the following: -The resident lay in his/her bed; -An assist rail was attached to the right side of the bed in the raised position; -The mattress did not fit appropriately and there was a gap between the mattress and the assist rail exposing the metal bed frame. Review of the resident's electronic medical record showed no evidence staff conducted a current inspection of the resident's bed frame, mattress or assist rails to identify areas of possible entrapment. 2. Review of Resident #36's quarterly MDS, dated [DATE], showed the following: -The resident had moderately impaired cognition; -He/She had impaired ROM in both lower extremities; -He/She required substantial/maximum assistance with rolling right and left in bed; -He/She was independent with lying to sitting on the side of bed. Review of the resident's quarterly bed rail assessment, dated 5/23/24, showed the following: -Quarter sized bed rails were used on both sides of the bed; -He/She demonstrated poor bed mobility or difficulty moving to a sitting position on the side of the bed; -There was no documentation of entrapment zone measurements. Review of the resident's care plan, last reviewed/updated on 5/28/24, showed the following: -The resident used bilateral bed rails to increase independence with bed mobility and activities of daily living (ADLs); -He/She was dependent on staff for bed mobility; (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She required the use of a mechanical lift for transfers. Observation on 6/17/24 at 1:49 P.M. showed the resident lay in his/her bed on a low air loss mattress (a type of mattress system that floats the resident on air-filled cells while circulating air across the skin). The resident's bed had half bed rails on both sides of the bed. The bed rails were in the raised position. Review of the resident's low air loss mattress's manufacturer guidelines showed no directions for bed rail use. Review of the resident's electronic medical record showed no evidence staff conducted an inspection of the resident's bed frame, low air loss mattress or assist rails to identify areas of possible entrapment. 3. Review of Resident #7's physician's orders, dated 3/20/24, showed an order for a low air loss mattress. Review of the resident's significant change MDS, dated [DATE], showed the following: -The resident had moderately impaired cognition; -He/She had impaired ROM of bilateral lower extremities; -He/She required substantial/maximum assistance with rolling right and left in bed; -He/She was dependent with sitting to lying flat on the bed; -He/She was dependent with lying to sitting on the edge of the bed. Review of resident's quarterly bed rail assessment, dated 04/05/24, showed the following: -Bilateral U-bar/cane assist rails; -No documentation of entrapment zone measurements. Observation on 06/17/24 at 12:53 P.M. showed the resident lay in bed on a low air loss mattress. Assist bars were in the raised position on both sides of the resident's bed. Review of the resident's low air loss mattress's manufacturer guidelines showed no directions for bed rail use. Review of the resident's electronic medical record showed no evidence staff conducted an inspection of the resident's bed frame, low air loss mattress or assist rails to identify areas of possible entrapment. 4. During an interview on 06/20/24 at 11:15 A.M., the Maintenance Director said the following: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Entrapment zone measurements were completed when bed rails were installed to see if rails were safe for use; -It was a group effort between therapy, nursing, and the maintenance department to ensure the bed rails were safe for resident use; -He thought the bed rail entrapment zones were supposed to be assessed monthly, but could not provide documentation that this was completed; -Resident #3's mattress did not fit appropriately. The resident had hyperactivity, but the mattress should not move, and the bed frame should not show. The mattress would need to be replaced with one that fit the bed frame for the resident's safety. He was not aware the mattress moved like that. During an interview on 6/20/24 at 3:20 P.M., the Administrator said he thought the entrapment zone measurements were completed when the resident had a change in status. 50189