STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265185	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Cape Girardeau	365 South Broadview Street Cape Girardeau, MO 63703

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31057 Based on observation, interview, and record review, the facility failed to provide reasonable accommodations of individual needs and preferences to ensure one resident (Resident #2) of five sampled residents has an acceptable bed with the correct width and length that encourages independent bed mobility. The facility census was 105. Review of the facility policy titled, Care of Bariatric Resident, dated 04/18/23, showed: - Severe obesity- weighing more than 250 pounds (lbs) or a body mass index of 40 kilograms (km) and is synonymous with the term bariatric; - The facility should consider the activation of bariatric protocols when admitting a resident who is 250 lbs or more; - Education should also address any negative feelings or fear related to the care of bariatric residents; - It is also important to assess and document, both during the admitting assessment and on a regular basis, the bariatric resident's ability to participate during repositioning , transferring, and ambulation. Review of the manufacturer's guidelines showed the measurements for the facility's standard sized beds were 34 inches () wide by 80 long. Review of the manufacturer's guideline showed the measurements for the facility's standard bariatric beds were 48 wide by 80 long. 1. Review of Resident #2's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by the facility staff), dated 06/02/24, showed: - An admitted [DATE]; - Cognition intact; - No rejection of care; (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Independent with eating; - One person physical assist with bathing; - Supervision and/or touch assistance of staff for rolling left and right in bed, sit to stand, lying to sitting, chair to bed, and toileting; - Foley catheter (a device that drains urine from the urinary bladder into a collection bag outside of the body); - Incontinent of bowel; - Hemodialysis (a treatment that filters waste and water from the blood) treatments; - Height 70 inches, weight, 290 lbs. Review of the resident's medical record showed: - Resident his/her own responsible party; - Diagnoses of clostridium difficile (c-diff - a bacteria that causes diarrhea and colitis), diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), end stage renal disease (medical condition where the kidneys stop functioning normally and can no longer filter waste from the blood), neurogenic bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should), morbid (severe) obesity, anxiety, and depression, cognitive communication deficit (trouble reasoning and making decisions while communicating), and history of Stage 3 pressure ulcer (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling); - Weight on 07/24/24 was 266.2 lbs., dialysis dry weight (the lowest tolerated post-dialysis weight achieved via gradual change in post-dialysis weight at which there are minimal signs or symptoms of hypovolemia (a decreased volume of circulating blood in the body) or hypervolemia (fluid overload, means there is too much fluid or blood in your body, which causes swelling): - Weight on last re-admission to the facility on [DATE] was 278 lbs. Review of the resident's progress notes showed: (continued on next page)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 08/12/24, the nurse was called to resident's room per a Certified Nurse Aide (CNA) who was attempting to perform incontinent care on the resident. The CNA said the resident slid off of the right side of the bed into the floor. Upon entering the resident's room, the resident was observed on his/her knees on the right side of the bed with the resident's arms wrapped around the side rail. the CNA said while attempting to perform care, the resident's legs started going off the right side of the bed with the CNA being on the left side of the bed. Once the resident's legs slid off of bed, the resident ended up in the position he/she was in when the nurse arrived. The resident kept repeating, I'm sorry, I'm sorry. Staff assured the resident that everything was ok. Additional staff was called in to assist in getting the resident assessed and back into bed using a a mechanical lift. The resident had no notable injuries at the time. The resident did not hit his/her head during the incident. The resident verbalized pain all over per the resident's normal complaints of pain and pain medication given. Observations on 08/22/24 at 10:35 A.M., showed the resident lay in a standard size bed with the use of a 1/4 assist bar to aide in assistance to turn and reposition self independently. The resident yelled and screamed while staff assisted with incontinent care for staff not to allow him/her to fall from the bed. During an interview on 08/22/24 at 10:35 A.M., Resident #2 said he/she was uncomfortable in the current bed, the bed was too small and he/she had a fear of falling out of the bed again. He/She had fallen out of the bed while receiving incontinent care with staff. He/She was afraid to move too much in fear of falling out. The resident talked with the Administrator yesterday and he was working on getting the resident a bigger bed like he/she had several months ago. During an interview on 08/22/24 at 11:00 A.M., the Administrator said he had spoken to the resident yesterday and was working on locating a bariatric bed for the resident to use. During an interview on 08/22/24 at 12:00 P.M., Registered Nurse (RN) D said the resident had a fall from the bed recently and now was afraid to roll in the bed independently. No interventions were added. During an interview on 08/22/24 at 12:05 P.M., Licensed Practical Nurse (LPN) B said the resident had never requested a larger bed to him/her, but did know the resident was terrified of falling out of the bed. No interventions were added. During an interview on 08/22/24 at 12:30 P.M., CNA C said ever since the resident fell out of the bed, he/she had a great fear of falling and now was refusing a bath and/or rolling over. The resident previously had a larger bed a while back, but when he/she returned this time from the hospital and placed in the current room, he/she had a regular size bed. No one provided any options or a larger bed for the resident. During an interview on 08/22/24 at 12:40 P.M., CNA E said the resident had spoken to someone about getting a bigger bed. When the resident was on a different hall, he/she had a larger bed. During an interview on 08/22/24 at 1:55 P.M., the Director of Nursing (DON) said she believed the weight requirement for a bariatric bed was 300 lbs., yet when referring to the facility policy, it was 250 lbs. The resident should have been placed in a bariatric bed upon re-admission to the facility on [DATE]. (continued on next page)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint # MO240798

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31057 jw KW Based on observation, interview, and record review, the facility failed to identify and treat a facility acquired pressure ulcer (injury to the skin and underlying tissue from prolonged contact with pressure) for one resident (Resident #2) out of five sampled residents. The facility's census was 105. Review of the facility's policy titled, Skin Wound, dated 08/25/21, showed: - Based on comprehensive assessment of a resident, the facility must ensure that a resident receives care consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; - A resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new pressure ulcers form developing; - A skin assessment/inspection should be performed weekly by a licensed nurse; - Skin observations also occur throughout points of care provided by Certified Nurse Aides (CNA) during activities of daily living (ADL's). Any changes or open skin areas are reported to the nurse. CNAs will also report to the nurse if the topical dressing is identified as soiled, saturated, or dislodged. The nurse will complete further inspection/assessment and provide treatment if needed. Review of Resident #2's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by the facility staff), dated 06/02/24, showed: - An admitted [DATE]; - Cognition intact; - No rejection of care; - Independent with eating; - One person physical assist with bathing; - Supervision and/or touch assistance of staff for rolling left and right in bed, sit to stand, lying to sitting, chair to bed, and toileting; - Foley catheter (a device that drains urine from the urinary bladder into a collection bag outside of the body); (continued on next page)

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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 0686 Level of Harm - Actual harm Residents Affected - Few	- Incontinent of bowel; - Hemodialysis (a treatment that filters waste and water from the blood) treatments; - No pressure ulcers. Review of the resident's medical record showed: - Resident his/her own responsible party; - Diagnoses of clostridium difficile (c-diff - a bacteria that causes diarrhea and colitis), diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine), end stage renal disease (medical condition where the kidneys stop functioning normally and can no longer filter waste from the blood), neurogenic bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should), morbid (severe) obesity (a chronic disease that occurs when someone has an excessive amount of body fat that can negatively impact their health), anxiety, and depression, cognitive communication deficit (trouble reasoning and making decisions while communicating), and history of pressure ulcer of other site, Stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Review of the resident's August 2024 Physician Order Sheets (POS) showed: Encourage resident to reposition every two hours, dated 07/16/24; - No orders for skin care and/or treatment of any wounds. Review of the resident's care plan, updated on 04/24/24, showed: - At risk for break in the skin integrity. Interventions of clean and dry the skin after each incontinent episode, a pressure reducing mattress, weekly skin checks, and a wheelchair cushion; - The resident was resistive to care, refused showers, wanted bed baths but when bed baths were offered, he/she refused them, refused to use toilet, lay in bed and soiled self, refused to assist with ADLs, and wanted staff to do all care. Interventions included allowing resident to amke decisions reagrding treatment to give a sense of control, educate resident regarding of the possible outcomes of not complyi ng with care and treatemets, and if resident resistive to care, leave and wait 5-10 minutes, return later and attempt care agian; - No changes to the skin integrity or noncompliance with care since 04/24/25. Review of the resident's Weekly Skin Integrity assessment, dated 08/19/24, showed blanchable (all redness disappears when light finger pressure is applied, indicating that the local capillaries are undamaged) area of redness to the coccyx and barrier cream applied. Shower sheets were not provided. Review of the resident's progress notes, dated 8/19/24 through 08/22/24, showed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- On 08/19/24, the resident refused to go to dialysis and refused labs to be completed for follow up care. Insisted on just lying in bed all the time. Resident educated on consequences of refusing dialysis, and the resident said, I know, and continued to refuse to go. Resident was incontinent of bowel. Peri care provided with each incontinent episode and PRN. Resident remained on contact isolation at this time for c-diff. Resident told the CNA that he/she did not want to be changed. Resident made aware that not being changed could result in skin integrity issues. The resident agreed to a bed check with reservations about pain when moved. Resident screamed out in pain often and staff encouraged the resident to use bed controls him/herself to control the rate in which bed was placed into position for optimal comfort of the resident and safe working position for the staff; - On 08/20/24, the resident insisted on just lying in bed all the time. - On 08/21/24, the resident insisted on just lying in bed all the time. Resident educated on consequences of refusing dialysis, and the resident said, I know, and continued to refuse to go. Resident incontinent of bowel. Peri care provided with each incontinent episode and PRN; - On 08/22/24, the resident insisted on just lying in bed all the time. The resident was incontinent of bowel. Peri care provided with each incontinent episode and as needed (PRN). During an interview on 08/22/24 at 12:40 P.M., CNA E said the resident refused to allow staff to change or reposition him/her frequently. CNA E said he/she noticed the open wound on the resident's buttocks sometime during his/her shift on 08/21/24, and reported the concerns to LPN B. CNA E could not recall the timing of when he/she reported the wound to LPN B. CNA E did not know what LPN B did. During an interview on 08/22/24 at 12:05 P.M., Licensed Practical Nurse (LPN) B said on 08/21/24, he/she assisted the CNAs with incontinent care of the resident. LPN B said he/she helped roll the resident toward him/her, and held the resident in position so he/she (resident) did not fall out of bed. LPN B said since he/she was facing the front of the resident, he/she could not see any of the resident's buttocks. LPN B said he/she did not assess the resident's skin during the care provided on 08/21/24. The CNAs did not report or say anything to him/her at that time about the resident having any open wounds. The resident was very difficult to handle and resisted or refused care frequently. Staff did encourage the resident to allow them to reposition him/her frequently due to being unable to reposition his/herself. Not sure what the facility policy was on pressure wounds, but should be documented and the physician notified for orders to treat. During an interview on 08/22/24 at 12:30 P.M., CNA C said he/she frequently cared for the resident, although he/she was unaware of the resident having any open wounds. If the staff noticed wounds and/or redness or anything abnormal, we were to immediately report the concerns to the nursing staff to follow up on. The resident did refuse care frequently and did not want to be repositioned in bed. Observations on 08/22/24 at 1:45 P.M., of the resident showed: - Right upper buttock area with open wound measured 3.4 centimeters (cm) x 1.9 cm, with an area of yellow slough (dead cells that accumulate in the wound) measured 1.2 cm x 1.1 cm. An area of necrotic (tissue death that occurs when there is not enough blood flow to the area) tissue measured 0.5 cm x 0.3 cm.; - Right lateral (side) buttock area with open wound measured 0.8 cm x 1.3 cm and reddened in color; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- Right medial (middle) buttock area with an open reddened area measured 3.5 cm x 0.5 cm and non-blanchable (redness that doesn't fade when pressure is applied). During an interview on 08/22/24 at 1:55 P.M., the Director of Nursing (DON) said she was not aware of Resident #2 having any open wounds. She would have expected the nursing staff to assess weekly and as needed due to the resident being a high risk for pressure ulcers and moisture associated skin damage with having c-diff. and continued refusals of care. Complaint # MO240798

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32751 Based on interview and record review, the facility failed to provide adequate supervision to safely transfer a cognitively impaired resident (Resident #1) out of five sampled residents, to the emergency room (ER). Facility staff sent the resident, unescorted, to the ER in a city cab instead of an ambulance after the resident experienced a medical problem. The facility census was 105. The facility did not provide a policy on safe transportation. 1. Review of Resident #1's admission Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by the facility staff), dated 07/31/24, showed: - An admitted [DATE]; - Cognitively impaired; - Diagnoses of atrial fibrillation (abnormal heart rate) and cognitive communication deficit (a cognitive deficit that affects verbal skills.) - The resident required assistance with all activities of daily living (ADL's). Review of the resident's Physician Order Sheet (POS), dated September 2024, showed: - An order for a peripherally inserted central catheter (PICC) line, dated 07/25/24; - An order for the PICC line to be flushed every shift, dated 07/25/24. Review of the resident's care plan, dated 07/25/24, showed: - The resident required assistance with all ADL's; - The resident was at [NAME] for falls due to muscle weakness; - The resident had decreased mobility. Review of the resident's Progress Notes, dated 08/15/24, showed Licensed Practical Nurse (LPN) A went to flush the PICC line and the PICC line had become dislodged. The nurse practitioner (NP) was notified and gave an order to send the resident to the ER for evaluation and reinsertion. A local cab transport was called to transport the resident to the ER. During an interview on 08/22/24 at 1:10 P.M., the Director of Nursing (DON) said she was aware the resident was sent by cab to the ER. She did not realize the resident was not cognitively intact. She would have expected LPN A to call an ambulance or send an escort with the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/22/24, LPN A said he/she noticed the PICC line was dislodged and went to call for an ambulance to transport the resident to the ER. He/She called the wrong number and the cab showed up. He/She did not know why the cab wasn't canceled and a call placed to the ambulance instead of placing the resident in the cab. It did not occur to him/her to send an escort as the resident seemed alert and oriented. LPN A did not check the medical record for the resident's cognitive ability before placing the resident in a cab. During an interview on 08/22/24 at 2:00 P.M., LPN B said he/she did not believe Resident #1 was capable of being sent out unattended due to the resident's confusion. During an interview on 08/22/24, the facility NP said he/she had no idea the facility was sending a cognitively impaired resident out in a cab. This information was not provided when LPN A called him/her. It was not a good practice to allow a cognitively impaired resident out unescorted. Complaint #MO240637