

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265209	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  New Madrid Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1050 Dawson Road New Madrid, MO 63869	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152</b></p> <p>Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) for two residents (Residents #10 and #28) out of 15 sampled residents. The facility census was 59.</p> <p>The facility did not provide a policy.</p> <p>1. Review of Resident #10's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), traumatic subdural hemorrhage (brain bleed affecting the body and how it works), seizure (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements like stiffness, twitching or limpness, behaviors, sensations, or states of awareness), aphasia (loss of ability to understand or express speech caused by brain damage), gastroesophageal reflux disease (GERD - stomach acid being forced back into the throat region), anxiety (persistent worry and fear about everyday situations), major depressive disorder (MDD - long-term loss of pleasure or interest in life), and osteoporosis (a condition causing loss of bone mass, predisposing a person to fractures);</li> <li>- An order for famotidine (used to treat acid reflux) 40 milligrams (mg) twice a day by mouth for GERD, dated 09/23/24;</li> <li>- An order for raloxifene (used to treat osteoporosis) 60 mg once a day by mouth for osteoporosis, dated 09/23/24;</li> <li>- No order for hypoglycemic (medications used to lower blood sugar) and antipsychotic (psychiatric medication used to treat psychosis) medications.</li> <li>- A care plan, dated 10/02/24, addressed dementia;</li> </ul> <p>Review of the resident's admission MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses of GERD, osteoporosis, and dementia not documented;</li> </ul> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- Received hypoglycemic and antipsychotic medications on a routine basis.</li> </ul> <p>2. Review of Resident #28's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of dementia, bradycardia (slow heart rate), depression, hemiplegia (paralysis of one side of the body) and hemiparesis (lack of sensation of one side of body) following a stroke affecting the right side, anxiety, type 2 diabetes mellitus (abnormal blood sugar), MDD, and GERD;</li> <li>- An order for pantoprazole (used to treat acid reflux) 20 mg once a day for GERD, dated 01/21/22;</li> <li>- No order for an antipsychotic medication;</li> <li>- A care plan, dated 08/01/24, addressed dementia;</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed:</p> <ul style="list-style-type: none"> <li>- Diagnoses of bradycardia, GERD, dementia, anxiety, and stroke not documented;</li> <li>- Received antipsychotic medication on a routine basis.</li> </ul> <p>During an interview on 10/10/24 at 9:25 A.M., the MDS Coordinator said he/she completed the MDS assessments. The residents' information was gathered from the charts, electronic records, and staff.</p> <p>During an interview on 10/10/24 at 10:21 A.M., the Director of Nursing (DON) said the MDS Coordinator used the Resident Assessment Instrument (RAI) manual to complete the MDS assessments.</p> <p>During an interview on 10/10/24 at 11:00 A.M., the DON and Administrator said they would expect the MDS to accurately reflect the resident's current condition.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49152</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain proper infection control practices for two residents (Residents #10 and #30) out of two sampled residents. This deficient practice had the potential to affect all residents in the facility. The facility's census was 59.</p> <p>Review of facility policy titled, Enhanced Barrier Precautions (EBP) to Infection Control Guidance, dated March 2024, showed:</p> <ul style="list-style-type: none"> <li>- Use of gloves and gown are required when conducting high-contact care activities to residents with indwelling medical devices.</li> </ul> <p>Review of the facility's policy titled, SARS-CoV-2 (Covid-19) For Long Term Care Facilities, dated 05/15/23, showed:</p> <ul style="list-style-type: none"> <li>- The strategies the Centers for Disease Control (CDC) recommends to prevent the spread of SARS-CoV-2 in long term care communities are the same strategies used every day to detect and prevent the spread of other respiratory viruses;</li> <li>- Keep residents and employees informed by describing what actions the facility takes to protect them;</li> <li>- Ensure facility employees are educated, trained, and have practiced the appropriate use of personal protective equipment (PPE) prior to caring for a resident;</li> <li>- Post signage regarding donning (putting on) and doffing (taking off) of PPE;</li> <li>- Healthcare personnel who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a N95 particulate respirator, gown, gloves, and eye protection;</li> </ul> <p>-While not recommended, residents who are on transmission based precautions (TBP) or quarantine can still receive visitors. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated). Before visiting residents, who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention and wear appropriate PPE.</p> <p>1. Review of Resident #10's medical record showed:</p> <ul style="list-style-type: none"> <li>- admitted [DATE];</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Diagnoses of traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury), dementia (a loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), malnutrition (a lack of sufficient nutrients in the body), and dysphagia (difficulty swallowing foods or liquids);</p> <p>- Physician Order Sheet (POS), dated 09/10/24-10/10/24, showed an order for Jevity 1.5 Cal (a type of tube feeding formula) bolus feeding of 10 ounces every four hours, dated 10/02/24;</p> <p>- Care Plan, last revised 10/02/24, showed EBP for the resident related to a gastrostomy tube (a tube inserted through the abdomen that brings nutrition, medications, and fluid directly to the stomach).</p> <p>Observation on 10/09/24 at 11:35 A.M., showed Licensed Practical Nurse (LPN) C failed to put on a gown prior to entering Resident #10's room to administer medication and feeding through the resident's gastrostomy tube.</p> <p>During an interview on 10/09/24 at 1:32 P.M., LPN C said EPBs were required for residents with gastrostomy tubes. Gloves and gowns were to be worn.</p> <p>During an interview on 10/10/24 at 11:00 A.M., the Director of Nursing (DON) said she would expect staff to use EBP per CDC guidelines when performing care on residents with an indwelling device, wound, or a transmissible organism.</p> <p>2. Review of Resident #30's medical record showed the resident tested positive for Covid-19 on 09/30/24, and placed on Covid-19 isolation precautions in a private room.</p> <p>Observations on 10/08/24 at 10:45 A.M., and 11:12 A.M., showed the resident's door was open and the resident sat unmasked in a wheelchair inside the room.</p> <p>Observations on 10/08/24 at 11:25 A.M., and 11:27 A.M., showed Certified Nurse Assistant (CNA) A wore a N95 mask, entered through the resident's opened door without putting on a gown or gloves, failed to close the door, and failed to change the N95 mask and to close the resident's door when he/she exited the room.</p> <p>Observation on 10/09/24 on 12:01 P.M., showed the resident's s room door was opened. The resident sat up in bed unmasked and eating.</p> <p>Observation on 10/09/24 at 12:11 P.M., showed CNA B entered the resident's room with an isolation gown and N95 mask on but failed to put on gloves. CNA B exited the resident's room with the meal tray and left the door open. CNA B failed to change N95 masks and to close the resident's door upon exiting the resident's room.</p> <p>Observation on 10/09/24 at 1:20 P.M., showed the resident's door was open with one staff in the room wearing appropriate PPE. The unmasked resident visited with two visitors with N95 masks on in the room but without gowns and gloves and the door open.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/08/24 at 1:40 P.M., CNA A said he/she did not know the resident was on Covid-19 precautions since the door was open. If the door was closed, then he/she would have looked at the door or the name tag beside the door to see if the resident was on precautions.</p> <p>During an interview on 10/10/24 at 11:00 A.M., the DON and Administrator said they expected staff to follow the CDC guidelines for isolation precautions.</p> <p>49999</p>		