STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265239	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hermitage Nursing & Rehab	18599 First Street Hermitage, MO 65668

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to implement a complaint infection prevention and control program when the facility failed to review and update their infection prevention and control program policies and procedures manual annually as required. The facility also failed to ensure all staff were trained regarding the use of Enhanced Barrier Precautions (EBP - refers to an infection control method using gowns and gloves for high-contact care of residents with or at risk for MDROs) and failed to follow EBP guidelines as indicate for three residents (Resident #5, #69, #40). Staff failed to follow standard infection control practices when providing cigarettes to two residents (Resident #49 and #68) who smoke when staff touched the filters with the bare hands without performing hand hygiene or donning gloves. Staff failed to complete proper hand hygiene during medication pass involving threes residents (Resident #53, #63, and #43). The facility census was 63. 1. Review of the facility Infection Prevention and Control Policy (IPCP) manual showed the following:-Initial date of the manual was April 2014;-The page entitled Infection Prevention and Control Plan Review was last signed and dated by the Medical Director and the Administrator on 02/06/24;-A document entitled Infection Prevention and Control Program showed Facility Name and Date were not specified;-Review and evaluate the infection prevention/control plan no less than annually and revise as necessary.-Program Evaluation showed no signed/dated approval by the Quality Assurance Committee, Administrator, and Medical Director. During an interview on 12/10/25, at 11:10 A.M., the Administrator said all facility policies were now kept electronically, and he/she did not think the facility did an annual review of the infection prevention and control policies and procedures. The Registered Nurse/Quality Assurance Consultant said he/she was aware of the regulation that required the annual review but had not been involved in that process for the facility. During an interview on 12/11/25, at 2:10 P.M., the MDS Coordinator/Infection Preventionist (IP) said he/she was not aware of the requirement for an annual review of the IPCP. During an interview on 12/11/25, at 2:50 P.M., the Administrator said he/she was not able to locate signed documentation by the Medical Director and the Administrator of an annual review of infection control policies and procedures. 2. Review of the Centers for Disease Control's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms, dated 07/12/22, showed the following:-Multidrug-Resistant Organisms (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs;-EBP are infection control interventions designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities;-EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;-Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care;-EBP use of PPE (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	placed on bedside table. CNA I entered resident room to assist. The staff washed their hands at the sink and applied gloves. Staff did not apply gowns. Staff assisted resident to roll to right side and completed wound care to upper right buttock. Staff removed gloves and wash hands at sink. The CNA left the room. The nurse applied gloves and removed the resident's foam boot from the left foot, completed wound care, and re-applied foam boot. The nurse removed gloves and washed hands at sink. The nurse applied gloves and pulled back covers and observed resident right side of right leg showed healed wound and returned covers and did not complete any wound care. The nurse washed hands at sink and left room. There was no EBP sign on door and no PPE readily available. The staff did not wear a gown while completing wound care. 6. During an interview on 12/12/25, at 9:28 A.M., CNA C said the following:-EBP means having barrier cream in the room;-The charge nurse or DON would let him/her know if a resident is on EBP;-He/She has not received any training on EBP, so he/she does not know for sure what that is;-He/She is not aware of any residents being on EBP. During an interview on 12/12/25, at 9:50 A.M., CMT D said the following:-EBP means staff should wear proper PPE such as gowns and gloves;-Residents on EBP should have a basket in their room with gowns available and a butterfly sticker on the wall outside his/her room;-Residents with infections, catheters, and intravenous lines should be on EBP;-On occasion, he/she receives an in-service on EBP. The training is different each month. During an interview on 12/12/25, at 11:04 A.M., LPN E said the following:-He/She has received training and education on EBP;-EBP consists of hand washing and wearing gowns and gloves. During an interview on 12/12/25, at 11:16 A.M., LPN B said the following:-The process of EBP involved handwashing, hand hygiene, and the use of gloves, and gowns;-EBP should be used with residents who have wounds, catheters, and infections;-Residents on EBP should have a butterfly sticker on the wall outside their door to alert staff. During an interview on 12/12/25, at 12:50 P.M., the DON said staff are expected to wear gowns and gloves with residents on EBP. During an interview on 12/12/25, at 1:03 P.M., the Administrator said staff are expected to use hand hygiene, gowns, and gloves for EBP. 7. Observation on 12/09/25, at 10:30 A.M., showed the following:-RN A entered the locked medication room and exited with three unpackaged resident cigarettes and one unpackaged resident cigar in his/her bare hands. The RN did not complete handwashing, hand sanitizing, or use of glove;-Housekeeper F pushed his/her work cart to the nurses' station, put his/her coat on, and received the individual, unpackaged cigarettes and cigar with his/her bare hands from RN A. The housekeeper did not complete hand washing, hand sanitizing, or use of gloves;-Housekeeper F held the cigarettes and cigar in one hand while also pushing one resident outside in his/her wheelchair using both hands;-At the outside designated smoking area, Housekeeper F handed each resident their cigarette/cigar with his/her bare hands, and lit them for each resident;-Housekeeper F smoked his/her own cigarette at the same time the residents were smoking. Observation on 12/10/25, at 1:12 P.M., showed the following:-LPN B entered the locked medication room and obtained three cigarettes by grabbing the filters from three separate cigarette packages with his/her bare hands. The LPN did not complete hand washing or hand sanitizing, and did not use gloves;-LPN B carried the cigarettes to the nurse's station with his/her bare hands and handed the cigarettes to Floor Technician G, who had just arrived at the nurses' station and had just put his/her coat on. The floor tech did not complete hand washing or hand sanitizing, and did not use gloves;-Floor Technician G took the cigarettes into his/her bare hands, touching each cigarette filter;-Floor Technician G kept the cigarettes in his/her right hand while attempting to push one resident outside in his/her wheelchair with both hands;-He/She was observed having difficulties holding the cigarettes while pushing the resident in his/her wheelchair;-Floor Technician G placed all three cigarettes in his/her coat pocket. 8. Review of Resident #49's face sheet showed an admission date of 06/11/25. Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the resident's care plan, dated 06/11/25, showed the resident smokes with potential for injury/adverse effects and required staff supervision during all scheduled smoke breaks. During an interview on 12/12/25, at 10:43 A.M., the resident said the following:-He/She would prefer that staff not touch his/her cigarettes with their bare hands;-He/She would like staff to give his/her cigarettes to him/her directly from the cigarette package, without touching them;-The resident felt like he/she could get an illness from staff due to them touching the filter of his/her cigarettes with their bare hands, especially with two staff touching the cigarettes with their bare hands every time he/she smokes. 9. Review of Resident #68's face sheet showed an admission date of 12/05/25. During an interview on 12/12/25, at 10:33 A.M., the resident said the following:-He/She did not like the staff touching his/her cigarettes with their bare hands;-He/She thought he/she could get sick from staff touching his/her cigarettes, especially since at least two staff members touch the cigarettes with their bare hands during each smoke break;-He/She does not want to get sick if staff do not wash their hands before touching his/her cigarettes with their bare hands;-The resident did not think it was appropriate for staff to put his/her cigarettes in their coat pocket after they remove them from the cigarette package;-He/She would like to have his/her cigarettes provided to him/her directly from the cigarette package, without staff touching them. 10. During an interview on 12/09/25, at 10:00 A.M., RN A said the following:-The charge nurse or another nursing staff member who has a key to the locked medication room will take an individual cigarette out of each resident's cigarette package while they are in the medication room and hand the individual cigarettes directly to another staff member in one of the following departments (restorative therapy, housekeeping, activities, dietary, or nursing), and that staff member hands the individual cigarettes to each resident once they reach the designated smoking area outside.-The facility currently has four smokers;-Residents are allowed to smoke up to seven times per day;-Residents are only allowed one cigarette per smoking event. During an interview on 12/12/25, at 9:28 A.M., CNA C said the following:-The nursing staff takes the individual cigarettes out of the locked medication room with their bare hands and hands them to the staff responsible for taking the residents out to smoke;-He/She assumed it was not appropriate for staff to touch the resident's individual, unpackaged cigarettes with their bare hands;-Staff should wear gloves when touching resident cigarettes;-It was not appropriate for staff to put resident cigarettes in their coat pocket while escorting residents outside to smoke;-There was a potential for residents to become ill from staff touching their cigarette filter with their bare hands and without the use of gloves. During an interview on 12/12/25, at 9:50 P.M., CMT D said the following:-The nurses or medication technicians pull one cigarette out of each resident's cigarette package with their bare hands while in the locked medication room and they hand the cigarettes to the staff that will be taking the residents out to smoke;-The cigarettes change hands a couple of times before the residents receive them;-The cigarettes packs never leave the medication room, only the individual, unpackaged cigarettes;-It is not appropriate for staff to touch the filters of the resident's cigarettes with their bare hands that have not been washed;-Usually, the housekeeping staff take the residents out to smoke;-It is not appropriate for staff to put the resident's cigarettes in their coat pocket while taking them out to smoke;-If staff is not using proper handwashing there is a potential for residents to become ill from staff touching the filter on their cigarettes with their bare hands and without gloves. During an interview on 12/12/25, at 11:00 A.M., Housekeeper F said the following:-He/She asked the charge nurse to get the resident's cigarettes out of the locked medication room for him/her;-He/She was a smoker, so he/she knew which unpackaged cigarette went to which resident without having the packaging. If he/she had any questions the charge nurse will show him/her which cigarette belongs to each resident;-It was not appropriate for staff to touch the resident's cigarettes with their bare hands that have not been washed or sanitized or without gloves;-It was not appropriate for two staff to touch the resident's cigarettes with their bare hands, especially the filter that the resident will be putting in their mouth;-It was not okay for staff to put the resident's cigarettes in their coat pocket while taking the residents out to smoke;-There is a potential for residents to become ill from staff (continued on next page)

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During an interview on 12/12/25, at 11:04 A.M., LPN E said the following:-The nurses have the key to the locked medication room, so they get the resident cigarettes out and hand them to the staff member that is scheduled to take the resident's out to smoke;-Individual cigarettes that have been removed from the packaging are handed to the staff that supervises the smokers;-It was not appropriate for staff to touch the resident's cigarettes, especially the filter of the cigarettes with their unwashed, non-sanitized, and non-gloved bare hands, but that is what has been happening;-It was probably not appropriate for staff to put a resident's unpackaged cigarette in their coat pocket;-Residents could become ill from staff touching the filter of their cigarette with their bare, ungloved hands, but that is what has been happening, even though staff try not to touch the cigarette filters. During an interview on 12/12/25, at 11:16 A.M., LPN B said the following:-Each resident gets one cigarette per smoke break;-Staff use their bare hands to obtain the cigarettes from the resident's cigarette package in the locked medication room;-The cigarette package does not go outside of the locked medication room;-Since only four residents smoke, he/she just remembers which cigarette each resident gets once the cigarettes are removed from the packages;-It was not appropriate for staff to touch the resident's cigarettes with their bare hands that have not been washed or sanitized or without wearing gloves, but that is what has been happening.-It was not appropriate for two staff to touch the resident's cigarettes with their bare hands, particularly the filter that the residents will be putting in their mouth;-It was not appropriate for staff to put the resident's cigarettes in their coat pocket while taking them out to smoke;-There was a potential for the resident to become ill from staff touching the filter of their cigarette with their bare hands and without using gloves. During an interview on 12/12/25, at 12:50 P.M., the Director of Nursing (DON) said the following:-The nurses and medication technicians have a key to the locked medication room where the cigarettes are kept. They obtain the cigarettes and pass them on to the staff scheduled to take the residents outside to smoke;-The cigarettes are handed to the residents outside the building;-The residents know what their cigarette looks like, and staff know which cigarette to give each resident since there are only three or four residents that smoke;-All staff are supposed to be wearing gloves to handle the resident's cigarettes;-It was not appropriate for staff to put individual, unwrapped cigarettes in their coat pocket while residents are being escorted outside the facility to smoke;-Unfortunately, yes there is a potential for the residents to become ill from staff touching the filters of the cigarettes with their bare hands and without the use of gloves. During an interview on 12/12/25, at 1:03 P.M., the Administrator said the following:-The nursing staff obtain the resident's cigarettes from the locked medication room and give them to staff that are responsible for taking the residents outside to smoke;-The facility has three smokers and they all smoke different kinds. The cigarettes are kept in a bin with the resident's name on it. Staff just know which cigarette to give each resident after they are removed from the cigarette package and the residents know which cigarette is theirs; -In his/her mind, staff should be wearing gloves to handle the individual, unpackaged cigarettes since the cigarettes are going into the resident's mouths;-Staff should not hold the cigarette at the filter for sure since that is the part the resident puts in his/her mouth;-It is not appropriate for staff to touch the cigarettes with their bare hands or put the cigarettes in their coat pocket;-There is always a potential for the resident to become ill from staff touching the filter of a resident's cigarette with their bare hands because we don't know if the staff washed their hands or not;-He/She prefers that staff wear gloves or have clean hands while touching the resident cigarettes. 11. Observation on 12/11/25, at 8:30 A.M., showed the following:-RN A applied gloves and picked up the glucometer (device for measuring the concentration of glucose in the blood, typically using a small drop of blood placed on a disposable test strip) from the top of the medication cart. The RN entered Resident #53's room. The nurse wiped the resident's right middle finger with an alcohol wipe, poked the finger with a lancet (small, sharp, pointed surgical blade used for making precise, small incisions or punctures), and obtained a blood sample onto the test strip attached to the glucometer. He/she left the room and disposed of supplies at the medication cart. He/she placed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	glucometer on a towel on the top of the medication cart. He/she did not wipe down the glucometer; -He/she removed his/her gloves and without completing hand hygiene he/she documented in the computer and applied new gloves. and went to the medication techs medication cart to obtain oxycodone (strong prescription narcotic used to treat moderate to severe pain) for the Resident #53. He/she pulled up 0.25 ml of oxycodone into the syringe. The syringe slipped and fell on the floor. The RN picked up the syringe from the floor and went to the cart and disposed of the medication and the syringe into sharps container with LPN A observing. The RN used the same gloved hands and looked through the medication cart and located a new syringe. He/she opened the syringe from the plastic wrap and pulled up 0.25 ml oxycodone. He/she then entered the resident room and administered oxycodone;-He/she left room and put syringe and oxycodone back to locked box. He/she removed gloves and documented medications. The nurse did not complete hand hygiene and moved the medication cart down the hall to the nurse station. Observation on 12/11/25, at 8:50 A.M., showed the following: -RN A applied gloves without completing hand hygiene between residents and obtained Trulicity injection (brand-name prescription medication used primarily to treat Type 2 diabetes (chronic condition that affects the way the body processes blood sugar (glucose)) for Resident #63. He/she then went down the hall and entered the resident's room and administered the injection to resident's abdomen. He/she then returned to the cart, disposed of syringe, and remove gloves. He/she used hand sanitizer on hands. Observation on 12/11/25, at 8:56 A.M., showed the following:-RN A applied gloves and picked up the glucometer from the top of the medication cart. He/she did not wipe down or sanitize the glucometer between residents. The nurse then wiped Resident #43's left middle finger with an alcohol wipe and poked the finger with lancet and obtained blood sample onto the test strip attached to the glucometer. The nurse then prepared Lantus Insulin Pen (prefilled injection device containing long-acting insulin glargine, a man-made insulin that helps control high blood sugar) and prepared Novolog Insulin Pen (prefilled injection device containing insulin aspart, a rapid-acting human-made insulin used to manage blood sugar levels). He/she then administered insulin in abdomen. The nurse disposed of the insulin needles and put away the insulin pens and removed his/her gloves. The nurse did not complete hand hygiene and moved on to the next resident. During an interview on 12/12/25, at 10:40 A.M., LPN B said staff should complete hand hygiene between each resident and each dirty to clean process. The glucometer should be cleaned with the sanitizing wipes on the carts. He/she said he/she should have worn a gown during wound care. During an interview on 12/12/25, at 11:45 A.M., MDS Coordinator/Infection Preventionist said the staff should complete hand hygiene between every resident and between dirty to clean tasks. The staff should clean the glucometer between each resident. During an interview on 12/12/25, at 12:30 P.M., DON said staff should complete hand hygiene between each resident interaction and the glucometer should be cleaned between each resident contact. During an interview on 12/12/25, at 12:50 P.M., the Administrator said the nursing staff should clean the glucometer between each resident and should be completing hand hygiene between each resident interaction, as well as between dirty and clean process, picking up an item on the floor then picking another clean item.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265239	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR - a two level tool used to screen each resident in a nursing facility for mental disorder or intellectual disability prior to admission) level one was retained in the resident's medical record and accessible for one resident (Resident #38) of four residents reviewed for PASARR. The facility census was 63.Based on record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR - a two level tool used to screen each resident in a nursing facility for mental disorder or intellectual disability prior to admission) level one was retained in the resident's medical record and accessible for one resident (Resident #38) of four residents reviewed for PASARR. The facility census was 63. Review showed the facility did not provide a written policy pertaining to PASARRs. 1. Review of Resident #38's face sheet (gives brief profile information) showed the following:-admission date of 06/11/12;-Diagnoses included paranoid schizophrenia (mental disorder characterized by intense delusions and hallucinations), bipolar disorder (mental health condition causing shifts in mood), borderline intellectual functioning (cognitive profile between normal intelligence and intellectual disability), major depressive disorder, and insomnia.Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 10/29/25, showed the following:-Mild cognitive impairment;-Diagnoses included bipolar disorder and schizophrenia;-Medications included routine antipsychotic, antidepressant, and antianxiety.Review of the resident's care plan, last reviewed/revised 10/29/25, showed the following information:-Potential for elopement and poor safety awareness;-Talk with psychologist every two weeks if willing to participate;-At risk for behaviors related to diagnosis of schizophrenia;-Administer medications as ordered and monitor effectiveness and adverse effects, offer interventions if behaviors occur;-Displays signs and symptoms of mood distress;-Encourage and allow resident to talk and verbalize feelings, be a good listener, non-judgmental, offer reassurance, even if it's incoherent or delusional;-Has delusions/hallucinations and believes they are real; -Reorient when needed if reorientation does not cause distress;-Observe for non-verbal signs of distress;-Experienced trauma in life since a very young age and may need assistance to address the physical, behavioral and or social impacts of the trauma;-Has developed fear, terror, dread or helplessness following exposure to a traumatic event of sexual assault/rape, mental abuse, and violence; -Actively listen to details and recollections surrounding the traumatic event; -Maintain safety and integrity during post-traumatic episodes using appropriate therapeutic interventions;-Impaired decision making and tends to isolate related to diagnosis of paranoid schizophrenia, bipolar, and depression;-Report worsening signs of isolation. Review of the resident's physician order sheet (POS), current as of 12/12/25, showed active orders for Abilify (an antipsychotic medication), bupropion hydrochloride (an antidepressant), divalproex (an anticonvulsant used to treat bipolar disorder), Invega Sustenna (an antipsychotic medication); sertraline (an antidepressant medication), and trazodone (an antidepressant medication) tablet.Review of the resident's medical record showed no copy/documentation of a completed Level 1 PASARR screening. During an interview on 12/12/25, at 12:06 P.M., the Assistant Director of Nursing (ADON) said the facility should obtain a copy of the completed Level 1 PASARR from the discharging hospital before a resident is admitted to the facility. If the resident is admitting from home, the facility should request a Level 1 or DA-124 as soon as possible through the resident's primary care physician (PCP). During an interview on 12/12/25, at 12:10 P.M., the Business Office Manager (BOM) said a Level One PASARR screening should be completed by the hospital prior to their facility admitting the resident. If triggered, a Level Two screening should also be completed. The facility should obtain and maintain copies of any screenings. If the resident is admitting from home, the facility should contact the resident's PCP to initiate a DA-124/Level One screening as soon as possible. The BOM said he/she had contacted the state agency (COMRU) and was told the original screening was no longer (continued on next page)

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	265239	A. Building B. Wing	12/12/2025

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available; the screening was done prior to 2013. The facility is requesting a replacement screening currently. During an interview on 12/12/25, at 12:30 P.M., the Director of Nursing (DON) said the Level One PASARR screening is to be completed by the hospital prior to discharging a resident to a skilled nursing facility; the Level Two is also to be completed if it was triggered/indicated. The facility should make sure they have the completed assessments prior to accepting the resident. If the resident is admitting from home, the facility should initiate the screening through the resident's PCP based on the diagnoses. During an interview on 12/12/25, at 12:35 P.M., the Administrator said the facility should have a copy of the Level One and/or Level Two PASARR screening(s) completed by the hospital for each resident. The facility did not have specific policies for the completion of the PASARRs, but they would follow guidelines and refer to the regulations.

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	265239	A. Building B. Wing	12/12/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to provide care per standards of practice when staff failed to provide wound care per physician orders for one resident (Resident #40's). The facility had a census of 63.Review of the facility provided policy, Wound Care and Treatment, undated, showed the following:-It is the purpose of this facility to prevent and treat all wounds;-There must be a specific order for the treatment. 1. Review of Resident #40's face sheet (brief information sheet about the resident) showed the following:-admission date of 06/18/24;-Diagnoses included nontraumatic intracerebral hemorrhage (severe type of stroke with high death rates), methicillin susceptible staphylococcus aureus infection (MSSA - common bacterial infection causing various infections, including skin issues to bloodstream infections), non-pressure chronic ulcer of skin (persistent skin sore lasting over four weeks that fails to heal normally), open wound right lower leg, blister of left foot, furuncle (pus filled skin abscess resulting from bacterial infection) of buttock open wound left lower leg, and pressure ulcer (skin and soft tissue damage from prolonged pressure) of unspecified site. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 11/21/25, showed the following:-Severe cognitive deficit;-Resident had pressure ulcer or injury over bony prominence;-Resident at risk for developing pressure ulcers. Review of the resident's care plan, last updated 12/04/25, showed the following:-Resident was at risk for skin issues related to bilateral lower extremity edema (swelling), incontinence (lack of voluntary control over urination), impaired functions, and mobility, and other disease processes;-Interventions will remain in place to reduce resident risk of skin impairment and breakdown to the extent possible with disease process;-Staff should follow treatment for all areas in place;-Staff should continue current plan of care. Review of the resident's Physician Order Sheet (POS), current as of 12/12/25, showed the following:-An order, dated 11/27/25, to apply skin prep (special liquid or wipe to the skin around a wound or medical device to create a protective, breathable film, preventing irritation) to right outer calf daily until healed;-An order, dated 12/04/25, to clean left heel area with wound cleaner, apply skin prep to peri-wound (skin and tissue immediately surrounding a wound), cover with island dressing, and change daily and as needed;-An order, dated 12/05/25, to cleanse upper buttock with wound cleaner, apply skin prep to peri-wound, apply calcium alginate (wound dressing to absorb fluid and create a moist healing environment) to wound bed, cover with island dressing, and change daily and as needed. Observation on 12/10/25, at 1:25 P.M., showed the following-Licensed Practical Nurse (LPN) B entered the resident's room with wound care supplies and placed them on the bedside table;-The LPN removed dressing from resident's upper right buttock and wiped the open area with wound cleanser on gauze. The nurse applied applied a small piece of calcium alginate to the wound, applied non-stick gauze and border tape over the wound, and initialed and dated tape. The LPN said he/she did not find any island dressing to apply (resident's orders stated to apply island dressing over calcium alginate);-The LPN removed the soft boot from residents left foot. No dressing covered the resident's heel. The LPN applied skin prep to the area approximately 2 centimeter (cm) in diameter, red area The nurse re-applied the soft boot over the left foot. (The LPN did not cover the heel with the ordered island dressing and did not clean the wound with wound cleanser as ordered.);-The LPN pulled back covers to observe the outer aspect of the resident's right leg. The area had a dried scab approximately 1/2 cm in diameter with no drainage and no redness. The LPN did not wipe with skin prep as he/she said the wound was healed;-The nurse returned the covers over the resident legs and did not complete any wound care. During an interview on 12/12/25, at 9:50 A.M., Certified Medication Tech (CMT) D said that staff should follow physician's orders when providing medications or completing treatments. During an interview on 12/12/25, at 10:40 A.M., LPN B said that staff should follow wound care orders. If the order states to use wound cleanser, skin prep, and cover with dressing the orders should be followed. If the order states to use skin prep until healed, staff should (continued on next page)

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	265239	A. Building B. Wing	12/12/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow the order. Staff should notify the doctor that wound is healed and discontinue the order. During an interview on 12/11/25, at 8:28 A.M., Registered Nurse (RN) A said staff should follow physician orders for wound care. If a wound was healed, the staff should notify the doctor and get approval to discontinue the order. During an interview on 12/12/25, at 11:45 A.M., the MDS Coordinator/Infection Preventionist said staff should follow physician orders when completing wound care or other treatments. The nursing staff should contact the doctor if the order needed discontinued. During an interview on 12/12/25, at 12:20 P.M., RN L said nursing staff should be following physician orders when completing wound care or treatments. During an interview on 12/12/25, at 12:30 P.M., the Director of Nursing (DON) said nursing staff should follow physician orders for wound care. The nurse should contact the doctor if the order needed to be adjusted or discontinued. During an interview on 12/12/25, at 12:50 P.M., Administrator said staff should follow physician's orders for wound care. If order states wound cleanser, skin prep and dressing, this should be followed. If the order is no longer relevant, if wound was healed, staff should get a new order to discontinue the wound care.

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	265239	A. Building B. Wing	12/12/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide respiratory care per standards of practice when staff failed to change oxygen tubing per professional standards, failed to document the change of oxygen tubing, failed to ensure appropriate storage of oxygen tubing that was not in use, failed to document pulse ox readings, failed to follow oxygen orders, and failed to ensure that the facility oxygen orders and the Hospice oxygen orders matched for one resident (Resident #5). The facility census was 63. Review of the facility's policy Oxygen Administration, undated, showed the following:-For nasal cannula, connect tubing to humidifier outlet and adjust liter flow as ordered;-At regular intervals, check liter flow contents of oxygen cylinder, fluid level in humidifier, and assess resident's respiration to determine further need for oxygen therapy;-Place cannula tubing in plastic bag attached to concentrator when tubing is not in use. 1. Review of Resident #5's face sheet (a brief information sheet about the resident), showed the following:-admission date of 08/12/21;-Diagnoses included atherosclerotic heart disease (a heart disease caused by plaque buildup in the arterial walls), chronic obstructive pulmonary disease (COPD - a lung disease that makes breathing difficult), hypoxemia (a lower than normal oxygen level in your blood), and heart failure. Review of the resident's admission Minimum Data Set (MDS- a federally mandated comprehensive assessment instrument completed by facility staff), dated 10/09/25, showed the following:-Moderate cognitive impairment;-Dependent on staff for toileting hygiene, shower/bathing, upper and lower body dressing, putting on and taking off footwear, rolling left and right, sit to lying, sit to stand, chair/chair-to-bed transfer, toilet transfer, and tub/shower transfer;-Partial to moderate assist for oral and personal hygiene;-Oxygen therapy;-Hospice care. Review of the resident's care plan, last revised 12/09/25, showed the following:-Resident receiving hospice services;-At risk for respiratory distress/infections related to seasonal allergies and COPD;-Interventions will remain in place to reduce risk of having signs of respiratory distress;-Administer oxygen as ordered;-Observe oxygen precautions;-Explain the importance of keeping oxygen at the prescribed setting;-Stress more oxygen may not be better;-Monitor and report signs of respiratory distress (restlessness, wheezing, dyspnea, difficulty with expectoration, diaphoresis, crackles, bubbling, tachycardia, cyanosis, decreased breath sounds) and report to charge nurse and physician;-Monitor oxygen saturation via pulse oximetry (pulse ox-device that measures blood oxygen) as ordered;-On 10/04/25, over the weekend, the resident had an episode of oxygen saturation being around 60%. Oxygen applied continuous, but resident would not leave it on continuous. Continue to encourage resident to use oxygen when necessary. Review of the resident's December 2025 Physician Order Sheet (POS), showed the following:-An order, dated, 05/19/22, for oxygen 2 liters per nasal cannula as needed for shortness of breath, or oxygen saturation below 92% room air;-An order, dated 05/19/22, to check oxygen saturation as needed and notify physician if less than 90%;-An order, dated 09/02/24, to change oxygen tubing and humidifier bottle weekly and as needed, place in plastic bag when not in use. Review of the resident's Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report, dated 10/17/25, showed the following:-On 09/29/25, the resident's oxygen saturation level was greater than 98% on room air;-A physician order, dated 10/05/25, for oxygen at 2 to 4 liters per nasal cannula as needed for comfort. Review of the resident's progress notes showed the following:-On 10/05/25, at 12:37 P.M., staff noted oxygen saturation initially 45%, rechecked and still low at 60%. No cyanosis (blue color) or respiratory distress. Oxygen placed per nasal cannula at first then switched to non-rebreather mask at 4 liters per minute. Staff notified hospice nurse notified. (Staff did not document physician notification of the low oxygen saturation);-On 10/05/25, at 2:50 P.M., staff noted hospice nurse present and assessed the resident. Hospice nurse recommended the resident wear oxygen continuously to maintain oxygen saturation greater than 90%.Review of the resident's Hospice IDG Comprehensive Assessment and Plan of Care Update Report, date 10/31/25, showed a physician order, dated 10/05/25, for oxygen at 2 to 4 liters (continued on next page)

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	265239	A. Building B. Wing	12/12/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as needed for shortness of breath.Review of the resident's progress notes showed the following:-On 10/06/25, at 6:06 A.M., staff noted oxygen saturation 92% on room air;-ON 10/06/25, at 6:55 P.M., staff noted oxygen saturation 74% on room air. Oxygen placed on resident and oxygen saturation increased to 90%. (Staff did not document the liters of oxygen the resident received or physician notification of the low oxygen saturation);-On 10/07/25, at 10:34 A.M., staff noted the resident's oxygen saturation was 78% on room air. Oxygen placed on the resident at 4 liters per minute to maintain oxygen saturation at 90%. (Staff did not document physician notification regarding the low oxygen saturation.) Review of the resident's Hospice Interdisciplinary Group (IDG) Comprehensive Assessment and Plan of Care Update Report, dated 10/17/25, showed the following:-On 10/07/25, oxygen saturation was 76% on 2 liters of oxygen;-On 10/10/25, oxygen saturation was 99% on room air;-On 10/15/25, oxygen saturation was 100% on room air. Review of the resident's Hospice IDG Comprehensive Assessment and Plan of Care Update Report, dated 10/31/25, on 10/17/25, oxygen saturation was 98% on room air. Review of the resident's progress notes showed the following:-On 10/24/25, at 5:31 P.M., staff noted oxygen saturation 95% on room air;-On 10/26/25, at 2:03 P.M., staff noted oxygen saturation 94% on 2 liters of oxygen;-On 10/26/25, at 6:33 P.M., staff noted oxygen saturation 95% on 2 liters of oxygen per nasal cannula. Review of the resident's Hospice IDG Comprehensive Assessment and Plan of Care Update Report, dated 10/31/25, showed on 10/28/25, oxygen saturation was 94% on 2 liters of oxygen. Review of the resident's October 2025 Treatment Administration Record (TAR) showed the following:-Staff did not document related to the oxygen tubing and humidifier bottle being changed weekly and placed in a plastic bag when not in use;-Staff did not document related to the resident's oxygen saturation being checked as needed or the physician being notified regarding an oxygen saturation of less than 90%;-Staff did not document related to oxygen 2 liters per nasal cannula being applied as needed for shortness of breath or oxygen saturation below 92% on room air. Review of the resident's progress notes showed the following:-On 11/02/25, at 2:27 P.M., staff noted oxygen saturation 96%. (Staff did not document regarding room air or liters of oxygen.);-On 11/06/25, at 3:32 P.M., staff noted resident continued to exhibit signs of decline and increased confusion. Oxygen saturation reading 70%, but likely inaccurate due to poor perfusion and nail beds cyanotic. Resident placed on oxygen but refused to wear it. (Staff did not document how many liters of oxygen were provided to the resident);-On 11/11/25, at 6:37 P.M., staff noted resident had 3 liters per minute of oxygen on at all times today. Review of the resident Hospice IDG Comprehensive Assessment and Plan of Care Update Report, dated 11/28/25, showed the following:-On 11/18/25, oxygen saturation was 97% on 2 liters of oxygen;-On 11/21/25, oxygen saturation was 96% on 2 liters of oxygen;-On 11/25/25, oxygen saturation was 100% on 2 liters of oxygen. Review of the resident's progress notes showed on 11/25/25, at 9:42 A.M., staff noted oxygen saturation 95% on 1.5 liters of oxygen. Resident had to be reminded to keep the oxygen on. Facility order was for 2 liters of oxygen and the Hospice order was for 2 to 4 liters of oxygen. Review of the resident's November 2025 TAR showed the following:-Staff did not document related to oxygen tubing and humidifier bottle being changed weekly and placed in a plastic bag when not in use;-Staff did not document related to the resident's oxygen saturation being checked as needed or the physician being notified regarding an oxygen saturation of less than 90%;-Staff did not document related to oxygen 2 liters per nasal cannula being applied as needed for shortness of breath or oxygen saturation below 92% on room air. Review of the resident's progress note dated 12/04/15, at 5:49 P.M., showed resident always wore oxygen and kept it in place. (Staff did not document related to the liters of oxygen the resident was receiving.) Review of the resident's December 2025 TAR showed the following:-Staff did not document related to the oxygen tubing and humidifier bottle being changed weekly and placed in a plastic bag when not in use;-Staff did not document related to the resident's oxygen saturation being checked as needed or the physician notified regarding an oxygen saturation of less than 90%;-Staff did not document related to the oxygen 2 liters per nasal cannula being applied as needed for shortness of breath or oxygen saturation below 92% on room air. Oservation on (continued on next page)

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	265239	A. Building B. Wing	12/12/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/08/25, at 12:59 P.M., showed the resident sat in his/her wheelchair in his/her room. Resident had oxygen on at 2 liters per nasal cannula. There was no date or staff initials on the oxygen tubing. Observation on 12/10/25, at 8:40 A.M., showed the resident sat in his/her wheelchair in his/her room. The resident received oxygen at 3 liters per nasal cannula per the use of a portable oxygen tank. There was no date or staff initials observed on the oxygen tubing attached to the portable oxygen tank. The regular oxygen concentrator was in the room with oxygen tubing attached and the tubing was lying on the floor under the resident's bed. There was no bag present to store the unused oxygen tubing in and no date or staff initials observed on the oxygen tubing attached to the regular concentrator in the room. Observation on 12/11/25, at 2:10 P.M., showed, the resident rested in bed with his/her eyes closed. Resident had on oxygen on 2 liters per minutes per nasal cannula. There was no date or staff initials on the oxygen tubing. During an interview on 12/12/25, at 9:28 A.M., Certified Nurse Aide (CNA) C said the following:-He/she did not know how many liters of oxygen the resident was on, but he/she thought the resident was on continuous oxygen all the time;-Typically, the nurses tell him/her if a resident is on oxygen and how many liters of oxygen they should be on;-Nurses adjust the oxygen titration or liters of oxygen for the resident;-There should be a physician's order for oxygen;-He/She was not sure who writes orders for residents on hospice. He/she does not look at hospice orders;-Typically, the facility orders in the resident's record should match the orders in their hospice record;-He/She was unsure who was responsible for transcribing or reconciling hospice orders in the resident's record;-He/She only obtains a pulse ox reading on a resident if the nurses tell him/her to do so;-He/She would document a pulse ox reading at the nurses' station and the nurses would enter the reading into the resident's record;-Nurses document the resident's liters of oxygen;-Med techs change the oxygen tubing, but he/she was not sure how often;-He/She assumed the med technician would document the tubing change in the resident's chart, but he/she was not sure how often they would chart the tubing change;-He/She thought there should be an order to change the oxygen tubing;-It was not appropriate for oxygen tubing to be laying on the floor;-If he/she saw oxygen tubing on the floor, he/she would throw it away and get new tubing for the resident;-The oxygen tubing should be put in a bag when it is not being used;-Typically, the oxygen tubing should be dated and initialed by staff when it is changed.During an interview on 12/12/25, at 9:50 A.M., Certified Medication Tech (CMT) D said the following: -The resident was on 3 liters of continuous oxygen;-He/She knew when a resident had oxygen and how many liters of oxygen they were on because they will have orders in the computer;-There should be a physician's order for oxygen;-He/She was responsible for setting up the resident's oxygen tanks for the number of liters ordered by the physician;-The facility oxygen orders and hospice oxygen orders should match in the resident's electronic medical record (eMAR);-The Director of Nursing (DON) and MDS Coordinator were responsible for transcribing or reconciling hospice orders in the resident's record;-CNA's, CMT's, and nursing staff should be checking the pulse ox status for residents on oxygen and documenting the readings in the resident's chart;-The CNA's should chart pulse ox readings in the computer and report to a nurse if a resident's pulse ox reading was less than 90%;-Staff should be documenting resident oxygen observations in the resident's record;-Oxygen tubing is changed by the CMT's every Monday and they should be documenting that in the resident's eMAR;-There should be an order in the resident's eMAR for staff to change oxygen tubing;-The bubbler on the oxygen concentrator should be labeled with the date it was changed, but not the oxygen tubing;-If he/she saw a resident's oxygen tubing on the floor, he/she would replace it with new tubing;-If the oxygen tubing and mask is not being used, it should be wrapped up and put in a zip lock bag. During an interview on 12/12/25, at 11:04 A.M., Licensed Practical Nurse (LPN) E said the following: -The resident was on continuous oxygen, but he/she was not positive how many liters of oxygen the resident is receiving;-Residents should have a physician's order for oxygen and the number of liters they require in their chart; -Nurses and CMT's adjust the liters of oxygen for residents;-The admitting nurse should ensure that the facility and hospice oxygen orders for each resident match;-Staff should be checking the pulse ox (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265239	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hermitage Nursing & Rehab	18599 First Street Hermitage, MO 65668

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reading of residents who are on oxygen, but the orders vary on how often;-The nurses are mostly the ones that check a resident's pulse ox status, and they should document the reading in the nurses eMAR;-Staff should be documenting resident oxygen observations in the eMAR;-CMT's change oxygen tubing weekly and they should have an order to change the tubing;-The date the tubing is changed should be on the bag or maybe the oxygen concentrator, but not usually on the tubing;-If he/she saw oxygen tubing on the floor, he/she would change the tubing;-If oxygen tubing was not in use, it should be stored in a bag.During an interview on 12/12/25, at 11:16 A.M., LPN B said the following: -The resident was on continuous oxygen, and he/she thought the resident was on 2 liters, but he/she would have to look at the resident's order to be sure;-Residents should have an order in their chart for oxygen, including the number of liters they should be on;-Nurses and CMT's are responsible for adjusting oxygen titration or liters of oxygen for the residents;-The facility oxygen order should match the hospice oxygen order for each resident. The hospice physician would write the oxygen order, and the nurses would transcribe or reconcile the order on the residents eMAR or TAR;-Staff should be checking the pulse ox reading on residents who have oxygen, but the frequency would depend on the resident specific order;-A resident's pulse ox reading should be recorded on the resident's MAR or TAR;-Resident oxygen observations by staff should be documented by the nurses in the residents eMAR;-Oxygen tubing should be changed weekly by CMT's and documented in the resident's eMAR or TAR;-There should be a physician's order on the TAR to change oxygen tubing;-Staff should label the oxygen tubing with the date it was changed and the staff's initials;-If he/she found oxygen tubing on the floor, he/she would change it;-Unused oxygen tubing should be stored in a bag. During an interview on 12/12/25, at 12:50 P.M., the DON said the following: -He/she believed the resident wore 3 liters of oxygen all the time, but he/she would have to double check that in his/her record;-There should be oxygen orders in the resident's record that the nurses and med techs can see;-Nurses chart on oxygen, but they never chart how much oxygen a resident is on;-Nurses monitor to make sure a resident's pulse ox reading is above 90%, but they monitor pulse ox status based on the circumstance. They also monitor for shortness of breath;-Nurses would document oxygen and pulse ox information on the eMAR or in a progress note;-There should be an order for the oxygen tubing, and it should be changed weekly by the CMT's and charted in the eMAR;-When the tubing is changed it should be labeled with the date it is changed and the staff's initials;-CNA's cannot see oxygen orders, so they would communicate with the nurses to know that information;-Nurses adjust the oxygen titration or liters of oxygen that a resident receives, and they communicate any concerns with the physician;-The physician writes the oxygen order and nurses enter the orders into the computer system;-Every hospice has their own physician, and they consult with the facility doctor. The nursing staff are responsible for transcribing or reconciling the residents' hospice orders in the facility record as soon as they receive them, so the orders match;-The facility physician orders say to maintain the resident's pulse ox reading above 90% and to check for shortness of breath;-Hospice does not have any routine orders to check a resident's pulse ox reading;-Residents who have a medication change or an order change will get vital signs taken and recorded in their record;-There should be a physician's order in the resident's electronic health record for oxygen tubing changes;-Staff should label the oxygen tubing with the date and their initials when it is changed;-CMT's should document oxygen tubing change in the CMT TAR. During an interview on 12/12/25, at 1:03 P.M., the Administrator said the following: -He/she had observed the resident wearing oxygen. The resident was supposed to have oxygen on all the time, but sometimes the resident refuses or takes it off;-The physician or nurse practitioner writes the oxygen order, and the nursing staff put the orders into the resident's electronic health record;-If a resident was on Hospice, the facility physician coordinated care with the hospice physician, and the facility nurse ensures that that the facility and hospice orders match in the resident's record;-The nurses are responsible for monitoring the resident's oxygen administration;-The nursing staff are responsible for setting the titration or liters of oxygen the resident is on based on physician orders;-Residents on oxygen should have a physician order for pulse (continued on next page)

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	265239	A. Building B. Wing	12/12/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ox checks and staff should document the pulse ox readings in the resident's electronic health record under the vitals section or MAR/TAR section;-CMT's change the oxygen tubing weekly and they should document the tubing change on the residents MAR/TAR;-Staff should label the oxygen tubing with the date and their initials when the tubing is changed;-If staff find oxygen tubing on the floor, they should wipe it off or sanitize it and place it in a bag.