STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265326	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Republic Nursing & Rehab	901 East Hwy 174 Republic, MO 65738

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 0580

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49585

Based on observation, interview, and record review, the facility failed to notify the physician of a change in resident condition and abnormal laboratory results in a timely manner for one resident (Resident #1). The facility census was 94.

Review of the facility policy titled, Condition Change, Resident (Observing, Recording, and Reporting), dated March 2015, showed staff are to observe, record, and report any condition change to the attending physician so that proper treatment can be implemented.

Review of the facility policy titled, Lab Reporting Guidelines, dated March 2015, showed the following information:

-Nurse will document resident name and lab ordered in the 24-hour report book and the date it is to be drawn;

-Nurse will notify the physician of lab results via fax and follow up call (within twelve hours for routine labs and within one hour for statim (STAT - as soon as possible) labs);

-Nurse will document on the lab report that the physician has been notified to include how they are notified, when, and nurse signature.

1. Review of Resident #1's face sheet (basic information sheet) showed the following information:

-admitted [DATE];

-Diagnoses included congestive heart failure (CHF - chronic condition where the heart does not pump blood as well as it should), atrial fibrillation (irregular heart rate), high blood pressure, fibromyalgia (disorder that causes pain and tenderness throughout the body), chronic kidney disease (gradual loss of kidney function over time), and chronic pain.

Review of the resident's Minimum Data Sheet (MDS - a federally mandated assessment tool completed by facility staff), dated 06/11/24, showed the following:

-Cognitively intact;

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER Republic Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 901 East Hwy 174 Republic, MO 65738	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Utilized a wheelchair for mobility assistance; -Required partial to moderate assistance with dressing, toileting, and personal hygiene; -Required set up and clean-up assistance for eating and oral hygiene; -Required supervision to touching assistance with bed mobility and transfers; -Dependent on staff for wheelchair mobility. Review of resident's Physical Therapy Evaluation, dated 06/11/24, showed the following: -Supervision or touching assistance needed for lying to sitting and sitting to standing; -Partial to moderate assistance needed with chair to bed transfer and toilet transfer; -Supervision or touching assistance needed to walk ten feet; -Partial to moderate assistance needed to wheel wheelchair fifty feet with two turns. Review of resident's Occupational Therapy Evaluation, dated 06/11/24, showed the following: -Set-up or clean-up assistance needed for eating, oral hygiene, personal hygiene, and upper body dressing; -Partial to moderate assistance needed with toilet hygiene and lower body dressing; -Substantial or maximum assistance needed with showering. Review of the resident's progress note dated 06/16/24, at 2:10 P.M., showed Licensed Practical Nurse (LPN) A documented a condition note for the resident. Resident had issues with fibromyalgia noted that day. Resident's arms have twitching on the right and the resident states there is some arm discomfort. Resident unable to stand and required total lift transfer. Resident incontinent of urine and stool, and stated he/she was not able to get up to toilet. Resident unable to feed self. Staff assisted resident with the meal. Resident ate very little and said he/she was not hungry. Resident expressed pain on movement out of bed. Four staff assisted with incontinent care and used of Hoyer lift (mechanical lift for residents who cannot bear weight) with transfer. Registered Nurse (RN) supervisor exam completed and call placed to family to update. (The nurse did not document notification of the resident's physician for the change of condition.) Review of the resident's progress note dated 06/17/24, at 1:52 P.M., showed LPN B documented resident lying in bed moaning this morning. Staff administered oxycodone (pain medication) and applied Bio freeze (topical pain relief). Resident complained of hurting all over. Therapy assisted resident out of bed at 10:45 A. M. Resident assisted back to bed and continued to moan and complain of pain. Resident stated he/she was full prior to eating lunch. Resident assisted with lunch and started to feed self, but arms noted to be weak and dropping from tray onto self. No signs or symptoms of distress noted at this time. (Staff did not document notification of the resident's physician for the change of condition.) (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's progress note dated 06/17/24, at 9:30 P.M., showed LPN C documented the resident roused to verbal stimuli and was able to answer simple questions. The resident then falls back asleep. Resident unable to feed self due to weakness and tremors of upper extremities. Resident refused evening meal and drank minimal fluids with staff assist. Resident was incontinent of bowel and bladder. Resident complained of all over generalized pain with stated relief from pain medication. (Staff did not document notification of the resident's physician for the change in condition.) Review of the resident's progress note dated 06/17/24, at 11:25 P.M., showed the Director of Nursing (DON) documented resident dependent on nursing staff for all cares and recently incontinent of bowel and bladder. (Staff did not document notification of the resident's physician.) Review of the resident's June 2024 Physician Order Report showed an order, dated 06/17/24, for complete blood count with differential (CBC - blood test that measures number of blood cells and platelets, including different types of white blood cells) and a basic metabolic panel (BMP - blood test that provides information about chemical balances and metabolism in the body). Review of the resident's laboratory results report, dated 06/17/24, showed the following: -Lab completed a blood draw on 06/17/24, at 6:15 A.M., for a CBC, BMP, and PT/INR; -Findings reported to the facility on [DATE], at 5:50 P.M.; -Elevated potassium 5.8 milliequivalent/Liter (mEq/L) (normal range 3.5-5.3 mEq/L); -Elevated blood urea nitrogen (BUN) 72 milligram/deciliter (mg/dL) (normal range 7-25 mg/dL); -Elevated creatinine 4.3 mg/dL (normal range 0.6-1.2 mg/dL); -Decreased GFR (indicates how well kidneys are function) level (define)10 mL/min (milliliter/minute) (normal range is greater than 60 mL/min). (The findings did not contain a nurse signature identifying physician notification of the abnormal labs.) During an interview on 07/24/24, at 11:55 A.M., a Lab Company Staff said labs were ordered for the resident on 06/17/24. The results for the labs were sent to the facility on [DATE], at 6:40 P.M. Review of the resident's progress note dated 06/18/24, at 9:28 A.M., showed RN E documented resident family verbalized concern for possible urinary tract infection (UTI - infection in part of the urinary system). Review of the resident's progress note dated 06/18/24, at 10:53 A.M., showed RN E documented nurse practitioner (NP)notified of family request for urinalysis (test of the urine) and new order received to obtain urine sample per family request. Review of the resident's June 2024 Physician Order Report showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Republic Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 901 East Hwy 174 Republic, MO 65738	

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 06/18/24, to obtain a urine sample via straight catheter (hollow tube placed in bladder to drain urine), for a diagnosis of difficulty in walking; -An order, dated 06/18/24, for Hoyer lift for transfers. Review of the resident's care plan, last reviewed/revised on 07/15/24, showed on 06/18/24 staff updated the care plan to show the resident unable to bear weight for transfers. Review of resident's Physical Therapy Discharge, dated 06/19/24, showed the following: -Substantial to maximum assistance needed for lying to sitting; -Dependent for sitting to standing, chair to bed transfer and toilet transfer. Review of resident's Occupational Therapy Discharge, dated 06/19/24, showed the following: -Set-up or clean-up assistance with eating; -Partial to moderate assistance needed for oral hygiene -Substantial or maximum assistance needed with toilet hygiene, upper body dressing, and showering; -Dependent for lower body dressing. Review of the resident's progress note dated 06/19/24, at 12:00 A.M., showed RN E documented urine sample obtained. Resident's urine was yellow, cloudy, and had a foul odor. Review of the resident's progress note dated 06/19/24, at 2:38 P.M., showed RN E documented resident seen by NP. Last lab results seen and showed possible renal failure (condition in which kidneys lose the ability to remove waste and fluids from the body). Staff received new order to send resident to hospital (three days after staff identified the change in condition and two days after staff received abnormal labs for the resident). Review of resident's hospital after visit summary, dated 07/02/24, showed diagnoses of UTI, severe sepsis with septic shock (condition in which body responds improperly to an infection), bacteremia (bacteria in the blood), acute kidney injury (condition where kidneys are suddenly not able to filter waste products from the blood), acute encephalopathy (condition that causes brain dysfunction). During interviews on 07/22/24, at 1:35 P.M., and on 07/24/24, at 11:51 A.M., LPN B said the following: -He/She would obtain vital signs, assess the resident, document findings, and notify the physician and family for any change in a resident condition; -The resident required increased assistance from staff and had an increase in pain and weakness sometime after admission to facility; -The family was aware of resident's change in condition; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She does not know if the physician was notified; -He/She should have notified the physician for the resident's change in condition, but can not recall if he/she did; -Lab results are faxed to medical records office and are placed in a box for nurse retrieval; -Administration staff are responsible for placing lab results in box; -Nurses should check for lab results once per shift; -Laboratory calls facility to report abnormal results; -Nurses should call abnormal labs in to the physician. During an interview on 07/24/24, at 11:24 A.M., the resident's NP said the following: -He/She will order STAT labs for acute concerns; -He/She was onsite at the facility on 06/19/24 and reviewed lab work that indicated the resident was in renal failure; -He/She did not recall the date of the lab work he/she reviewed; -He/She had the resident sent to the hospital for evaluation; -He/She did not recall being notified of any significant change in the resident's condition or concerns with lab results prior to being onsite 06/19/24; -The facility should notify him/her or the physician immediately of any significant changes in a resident's condition; -Routinely ordered labs should be reviewed by the facility for any urgent concerns and contact the NP or physician immediately if there are concerns. During interviews on 07/22/24, at 2:19 P.M. and 3:38 P.M., LPN A said the following: -He/she would assess the resident, obtain vital signs, call the physician for orders, and contact family for a change in resident condition; -He/She observed a change in the resident's condition, obtained vital signs, and notified the RN supervisor and the residents family; -He/She did not contact the physician due to normal vital signs and comments made by family and supervisor. During an interview on 07/22/24, at 3:54 P.M., RN H said the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Changes in condition should be reported to the charge nurse immediately; -Changes in condition should be reported to the physician immediately by the charge nurse and documented in the nurses notes. During an interview on 07/24/24, at 11:03 A.M., LPN F said the following: -Abnormal findings such as a change in vital signs, functional status, or mentation would indicate a change in condition; -He/She would obtain vital signs, document, and notify physician, family, and RN supervisor for any change in resident condition; -Lab results are faxed to facility and nurses and physicians can view them online; -Lab calls facility for critical results; -Guidelines of abnormal lab values are posted at the nurses' station which shows the nurse when to contact the physician; -He/She would call the physician for critical lab results; -Facility policy is to notify physician of abnormal lab results. During an interview on 07/24/24, at 11:23 A.M., LPN D said the following: -Change in condition should include any changes from the resident's baseline; -He/She would obtain vital signs, gather information on current labs, vitals, medications, notify physician, and document findings and any orders; -Nurses report lab values to the physician via email or online; -Lab calls facility for critically high or low lab values; -Facility policy is to notify physician as soon as possible of lab results. During an interview on 07/24/24, at 12:56 P.M., the Assistant Director of Nursing (ADON) said the following: -Lab results are received to medical records and can also be viewed online; -Nursing staff are to check each shift for received lab results; -Nursing staff are to review received labs for any immediate concerns and notify the physician if concerns are noted; (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The physician is to be notified of any changes in condition immediately by the charge nurse or abnormal labs and documented in the progress notes. During an interview on 07/24/24, at 12:20 P.M., the DON said the following: -Nurses should conduct an assessment and notify the physician and family for any change in resident condition. -A change of condition could include increased fatigue, change in functional abilities, and new onset of weakness. -Lab results are faxed to the front office. -He/she expects nurses to check for lab results. -Nurses should immediately notify physician of critical lab results. -There is no set procedure for lab results. -There is no facility policy related to labs. During an interview on 07/24/24, at 12:32 P.M., the Administrator said the following: -Resident changes in condition are to be reported to the physician immediately by the charge nurse and documented in the progress notes; -Lab results are received to the front office fax and are checked multiple times daily by nursing staff; -The physician is to be notified in a timely manner of any abnormal lab results by the charge nurse. MO00239092 41559

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49585 Based on observation, interview, and record review, the facility failed to use appropriate infection control measures to prevent or reduce the risk of spreading bacteria or other infectious causing contaminants when staff failed to provide a clean barrier for supplies, failed to appropriately wash hands, and failed to appropriately utilize personal protective equipment for one resident (Resident #2) during wound care and one resident (Resident #3) during blood sugar checks and insulin administration. The facility census was 94. 1. Review of the facility's policy and procedure for Wound Care and Treatment, dated March 2015, showed the following: -Medications should be for one designated resident only except for large volume liquids. These may be poured into a cup to take to the bedside; -Set-up supplies on a clean surface at bedside. Cover the surface with a clean, impervious barrier prior to setting supplies down. Supplies are never placed on the bed. -Place soiled scissors on one corner of the setup, not touching any other supplies. -Clean scissors with 60 seconds of contact with alcohol and place on clean corner of setup. Review of Resident #2's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted [DATE]; -Diagnoses included diabetes mellitus (condition where blood sugar is too high), cerebrovascular accident (damage to the brain due to interruption of blood supply), right sided hemiplegia (paralysis), and high blood pressure. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 04/13/24, showed the following: -Difficulty communicating; -Total dependence for mobility, transfers, toileting, and dressing; -Required moderate staff assistance with eating; -Resident had a pressure ulcer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's July 2024 Physician Order Sheet (POS) showed an order, dated 07/11/24, to clean left ischial (rounded bone that extends from the curved bone that makes up the bottom of the pelvis) wound with wound cleanser, pat dry, apply medifil 11 particles (wound dressing) 1/4 thick to wound surface (do not pack tightly; allow for expansion of particles) cover with non-adherent dressing and then foam dressing every three days and as needed. Review of the resident's care plan, dated 07/18/24, showed the following: -Resident has an open area on his/her buttocks. -Staff should ensure good infection control measures and personal protective equipment (PPE) are used with resident. -Resident had history of pressure ulcers and is at risk for additional skin impairments. Observation on 07/22/24, at 10:32 A.M., showed the following: -Licensed Practical Nurse (LPN) B obtained supplies from the treatment cart and entered the resident's room to provide wound care. -LPN B placed the wound care supplies, including wound cleanser bottle, bandage, gauze, wound medication, and scissors, on resident's bed without a barrier (possibly contaminating supplies or resident's bed with infectious organisms). -LPN B washed his/her hands and placed gloves. The LPN did not don a gown. -The LPN provided wound care to resident and then removed his/her gloves and picked supplies up from the bed and placed them on resident's dresser. -LPN B washed hands and then picked supplies up from the dresser and placed wound cleanser and scissors on top of treatment cart without cleaning them (possibly contaminating treatment cart or other residents with infectious organisms). -LPN B then pushed treatment cart to the nurses' station and walked away leaving scissors and wound cleanser on top of cart. 2. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Diagnoses included diabetes mellitus, chronic kidney disease (gradual loss of kidney function), and congestive heart failure (CHF - condition where heart doesn't pump blood as well as it should). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Required substantial to maximum staff assistance with dressing, transfers, and bed mobility; -Required moderate staff assistance with eating; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Received insulin injections. Review of the resident's care plan, dated 07/11/24, showed staff did not care plan related to the resident's diabetes diagnosis. Review of the resident's July 2024 POS showed the following: -An order, dated 04/15/24, for accucheck (machine used to check blood sugar level) three times a day before meals; -An order, dated 06/18/24, for Novolog Flex Pen insulin (medication used to lower blood sugar) per sliding scale. If blood sugar was less than 70 milligrams/deciliter (mg/dL) call the physician; if blood sugar was 120 mg/dL to 160 mg/dL, give one unit of insulin; if blood sugar was 161 mg/dL to 200 mg/dL, give two units of insulin; if blood sugar was 201 mg/dL to 240 mg/dL, give three units of insulin; if blood sugar is 241 mg/dL to 280 mg/dL, give four units of insulin; if blood sugar is 281 mg/dL to 320 mg/dL, give five units of insulin; if blood sugar was 321 mg/dL to 360 mg/dL, give six units of insulin; if blood sugar was greater than 360 mg/dL, call physician. Observation of blood glucose testing and medication administration on 07/22/24, at 10:53 A.M., showed the following: -LPN G prepared the resident's supplies for a blood glucose reading at the medication cart located at the nurses' station. -The LPN entered the resident's room after he/she applied gloves and gathered supplies. The LPN placed all supplies on the resident's blanket (potentially contaminating supplies and resident belongings). -The LPN pierced the resident's finger with a lancet and placed the used lancet on the resident's bed. The LPN applied blood to test strip. The LPN placed the glucometer (machine used to test blood sugar) with test strip inserted on the resident's bed. -The LPN covered resident, gathered supplies from bed, turned room light off, and walked to the nurses' station while wearing used gloves. -LPN G placed the glucometer and a test strip containing blood on the medication cart without a barrier (potentially allowing the cart to encounter infectious organisms). -The LPN removed his/her used gloves, sanitized his/her hands, and cleaned the glucometer. The LPN did not clean the medication cart where the used glucometer was placed. -The LPN checked orders for insulin and obtained and prepared the resident's insulin pen from the medication cart. -The LPN entered the resident's room with gloves on and placed the insulin pen on the bed (causing possible contamination of resident belongings or medication). The LPN administered the medication and placed the pen down on the resident's bedding. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN G covered resident and gathered used pen from bed, turned off the room light and walked to nurse station while wearing used gloves. The LPN obtained medication cart keys from his/her pocket, unlocked the medication cart, opened the drawer, and obtained an alcohol wipe with used gloves on. LPN G cleansed the insulin pen with the alcohol wipe, removed a clean glucometer from a cup on cart, and placed insulin pen and glucometer in the cart drawer while still wearing the same gloves used for resident care. (LPN G's used gloves had possibly contaminated all items touched after leaving the residents room with infectious organisms.) -The nurse then removed gloves and went to wash hands. 3. During an interview on 07/22/24, at 1:35 P.M., LPN B said the following: -Staff should place wound care supplies on a clean table in resident room; -He/She used a barrier for wound supplies sometimes; -He/She did not think of using a barrier while providing wound care on Resident #2; -Nurses should clean scissors between resident care; -He/She did not think to clean scissors with Resident #2, but cleaned them later; -Staff should dispose of used gloves and wash hands prior to leaving resident room. 4. During an interview on 07/22/24, at 2:19 P.M., LPN A said the following: -Nurses should place wound care supplies and glucometer on a barrier in resident rooms; -He/She would not place any supplies down on a resident bed; -Staff should clean scissors with a bleach wipe between residents; -Staff should not wear gloves out of room after resident care. 5. During an interview on 07/22/24, at 3:00 P.M., the Assistant Director of Nursing (ADON) said the following: -Supplies should be on a clean bedside table or field and not placed on a resident bed; -Staff should sanitize supplies used by multiple residents before and after use; -Staff should dispose of used gloves and perform hand hygiene; -Staff should not wear used gloves out of resident room. 6. During an interview on 07/22/24, at 3:00 P.M., the Director of Nursing (DON) said the following: -It is not acceptable to place supplies on a resident's bed; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should disinfect supplies used by multiple residents. 7. During an interview on 07/24/24, at 12:32 P.M., the Administrator said the following: -Staff are expected to follow appropriate infection control procedures; -He was unsure of the specifics; -The ADON is in charge of infection prevention. MO00239092 41559