STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265333	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire Senior Living Jonesburg	308 Cedar Avenue Jonesburg, MO 63351

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 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** 47193 Based on observation and interview, facility staff failed to use appropriate infection control procedures to prevent or reduce the risk of spreading bacteria, when staff failed to wash or sanitize their hands in between glove changes when providing wound care for four residents (Resident #1, #2, #3, and #4) of four sample residents. The facility census was 62. 1. Review of the facility's policy titled, Wound Care and Treatment, dated 03/2015, showed staff were directed to do the following: -Hand washing must be done as outlined in the guidelines; -Put gloves on; -Remove the soiled dressing and place in the trash bag; -Remove the gloves and discard in the bag; -Wash your hands and put on clean gloves; -Clean the wound according to the order; -Remove gloves, place in trash bag, and put on a clean pair of gloves; -Apply clean dressing as ordered; -Wash your hands. 2. Review of the Resident #1's Quarterly Minimum Data Set (MDS), a federally mandated assessment, dated 01/03/24, showed the staff assessed the resident as follows: -Severe cognitive impairment; -Risk for pressure ulcers; -Stage III (Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia) pressure ulcer. (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: 265333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024
NAME OF PROVIDER OR SUPPLIER: Aspire Senior Living Jonesburg		STREET ADDRESS, CITY, STATE, ZIP CODE: 308 Cedar Avenue Jonesburg, MO 63351	

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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 - Few	Observation on 04/12/24 at 12:40 P.M., showed Licensed Practical Nurse (LPN) A entered the resident's room to provide wound care to the resident's left foot toe. LPN A prepped the resident for wound care, removed gloves and then replaced them without hand hygiene. LPN A removed the residents bandages. With the same soiled gloves, LPN A opened the treatment cart and removed a barrier to place under the resident's foot. LPN A removed his/her gloves and applied new gloves without hand hygiene. Observation showed he/she cleaned the residents wound, removed his/her gloves, and applied new gloves without hand hygiene. With the same soiled gloves, LPN A bandaged the wound, covered the resident with his/her blanket, adjusted the bed and placed the call light and remote within reach. 3. Review of the Resident #2 Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Risk for pressure ulcers; -Stage III pressure ulcer. Observation on 04/12/24 at 1:55 P.M., showed LPN A entered the resident's room to provide wound care to the resident's left heel. Observation showed he/she applied his/her gloves. LPN A removed the residents heel protector, sock, and bandage. Observation showed LPN A continued to wear the same gloves, cleaned and dried the wound. LPN A removed his/her gloves and applied new gloves without hand hygiene. LPN A applied the triple antibiotic ointment, applied the wound treatment, dated and initialed the wound dressing. With the same soiled gloves, LPN A applied the residents sock, heel protector, and blankets. 4. Review of the Resident #3 Quarterly MDS, dated [DATE], showed staff assessed the resident as follows: -Severe cognitive impairment; -Risk for pressure ulcers; -Stage II (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising.)pressure ulcer. Observation on 04/12/24 at 2:15 P.M., showed LPN A entered the resident's room to provide wound care to the resident's right ankle. Observation showed LPN A applied gloves without hand hygiene. Observation showed LPN A removed the resident's sock and wound bandage. With same gloves LPN A cleaned the right ankle wound. LPN A changed his/her gloves without hand hygiene and applied the resident's Medihoney ointment (medical-grade honey intended for wound care) and bandage. 5. Review of the Resident #4 Annual MDS, dated [DATE], showed staff assessed the resident as follows: -Moderate cognitive impairment; -Risk for pressure ulcers; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Stage II pressure ulcer. Observation on 04/12/24 at 2:32 P.M., LPN A entered the resident's room to provide wound care to the resident's sacrum. LPN A applied gloves without hand hygiene. LPN A cleaned the resident's wound and removed his/her gloves. LPN A did not wash his/her hands and touched the wound packing sponge, cut a piece to wound size, placed the reminder of the packing back into the package and placed it in the treatment care. During an interview on 04/12/24 at 3:15 P.M., LPN A said he/she should have used gloves before touching the packing sponge. He/She said they have no protocol on storing it, but they are allowed to use it on multiple residents. He/She said he/she would not consider it clean since he/she touched it, but he/she didn't think about it before because his/her hands were clean. During an interview on 4/16/24 at 1:57 P.M., the Director of Nursing (DON) said staff should use gloves when handling the foam dressing. He/She said touching the foam is an infection control concern and lead to infections. 6. During an interview on 04/12/24 at 3:15 P.M., LPN A said staff should clean their hands when they enter and exit a resident's room, in between dirty and clean tasks, and glove changes. He/She said he/she did not provide hand hygiene during wound care because he/she was nervous. He/She said it is a risk for spreading germs and infection. During an interview on 4/16/24 at 1:57 P.M., the DON said it is his/her expectation that nurses who are performing wound care should wash their hands before and between glove changes. He/She said nurses should change their gloves between clean and dirty tasks, so they do not spread germs. During an interview on 4/16/24 at 2:10 P.M., the administrator said he/she expects his/her staff to perform hand hygiene when entering and exiting a resident's room and between tasks during wound care. He/She said he/she expects staff to wear gloves when prepping wound care supplies. He/She said it is an infection control concern. MO00234467