STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265389	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southbrook Nursing Center	1101 Hazel Lane Farmington, MO 63640

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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 0568 Level of Harm - Potential for minimal harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. 46555 Based on interview and record review, the facility failed to maintain a system to ensure the resident trust fund account was managed in accordance with proper accounting principles by not maintaining an accurate accounting of all monies held in the resident trust fund petty cash. This had the potential to affect all residents residing in the facility. The facility's census was 87. The facility did not provide a policy. Review of the facility-maintained resident petty cash log on 11/21/24 at 2:46 P.M. showed the balance listed as $553.88. Observation of the resident petty cash box count on 11/21/24 at 2:46 P.M. showed the Business Office Manager (BOM) counted a total of $453.88. The BOM said they keep $100.00 at the nurse's stations for residents to be able to access money during nights and weekends. Observation of the petty cash count from the nurse's station showed $60.00 in the cash bag, with $40.00 in completed receipts, which would total the $100.00. The nurse's station log indicated a balance of $65.00, for a discrepancy of $5.00. During an interview on 11/21/24 at 3:00 P.M., the BOM said charge nurses are supposed to be counting the cash each shift and putting the correct balance on the log. Sometimes the nurses don't count it, so the balance is off. He/she will reconcile it and figure out where they were off and add to the night withdrawal bag to get the total back to $100 for the weekends every week. If it is ever short money, the facility will replace any missing money. They have had a difficult time with agency staff not keeping correct count. During an interview on 11/21/24 at 3:58 P.M., Licensed Practical Nurse (LPN) A said he/she worked 6:00 A.M. to 2:00 P.M. on 11/20/24 and when he/she counted, the count was $65.00. On the line dated 11/19, both the signatures were on there, but a total was blank, so he/she added the total of $65.00 after looking through the signed receipt forms and figuring out what the total should have been. LPN B signed out $5 on his/her shift from 2:00 P.M. to 6:00 A.M., so the total should have been listed as $60 instead of $65 when he/she signed out for his/her shift. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0568 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 11/22/24 at 2:00 P.M., LPN B said he/she didn't do the money count when he/she came on shift because he/she was getting report. The other nurse counted and he/she signed for it later. He/she didn't know if the nurses are supposed to do the count together. He/she completed the request form when the resident requested $5 and put it in the book, which would have dropped the total to $60.00. He/she left in the middle of the shift because he/she was only filling in for a short while from 2:00 P.M. to 6:00 P.M. He/she did not have the keys to count the money when he/she left, so he/she signed the form, did a hand off report and left. The nurse that came on the shift after him/her should have counted and signed the new amount on the form. During an interview on 11/22/24 at 4:15 P.M., the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Social Services Director said the resident funds petty cash logs should accurately reflect what money is available for residents to spend.

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 46555 Based on interview and record review, the facility failed to maintain the surety bond (a purchased bond for security of residents' personal funds) for at least one and one-half times the average monthly balance of the residents' personal funds for the last 12 consecutive months from November 2023 through October 2024. The facility's census was 87. Review of the facility's policy titled, Process for Ensuring Sufficient Surety Bond Amount, dated April 2022, showed: - Upon receipt of the resident trust bank statement for any quarter, the Business Office (or Administrator) will acknowledge the balance on the bank statement; - They will then refer to the communication from home office that indicates the amount of the surety bond for their facility; - They will multiply the bank balance by 1.5 (or 150%); - If the surety bond amount is less than the bank balance at 150%, the Business Office or Administrator will reach out to the Chief Financial Officer (CFO) or home office to get the surety bond increased; - Home Office or the CFO will inform the facility when the bond amount has been updated. Review of the residents' personal funds account for the last 12 consecutive months from November 2023 through October 2024 showed: - The facility's approved bond amount equaled $65,000.00; - The average monthly balance of the residents' personal funds equaled $43,973.75; - An average monthly balance of $43,973.75 rounded to the nearest thousand equaled $44,000.00, at one and one-half times would equal the required bond amount of at least $66,000.00. During an interview on 11/21/24 at 3:00 P.M., the Business Office Manager said he/she didn't realize their accounts had increased the amount they had and didn't realize their bond wasn't high enough. He/She has a new bond for $75,000.00 dated for 11/21/24. He/She will get it sent in for approval before the end of the day. During an interview on 11/22/24 at 4:15 P.M., the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Social Services Director said they would expect their bond to be sufficient to cover the residents' funds.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49879 Based on interview and record review, the facility failed to follow their policy to ensure the Criminal Background Check (CBC), Employee Disqualification List (EDL - a listing of individuals who have been determined to have abused or neglected, misappropriated funds or property from a resident) and the Nurse Aide (NA) Registry were completed prior to the employment start date for three employees out of 10 sampled employees. The facility's census was 87. Review of the facility's policy titled, Abuse, Neglect, and Exploitation revised July 2023, showed: - The names of all potential employees will be checked against the list maintained by the State of persons who may not be eligible for employment within a long-term care facility. CNA registry checked on all new hires and print copy for employee file prior to employment date and according to state law. EDL checked in Missouri skilled facilities only. Review of the facility's policy titled, Background Screening Investigations, revised November 2015, showed: - Our facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on direct access employees. For the purpose of this policy direct access employee means any individual who has access to a resident or patient of a long term care (LTC) facility or provider through employment or through a contract and has duties that involve one on one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the National Background Check Program; - For any individual applying for a position as a Certified Nursing Assistant, the state nurse aide registry will be contacted to determine if any findings of abuse, neglect, mistreatment of individuals, and/or theft of property have been entered into the applicant's file. 1. Review of Certified Medication Technician (CMT) N's personnel file showed: - Hire date of 05/13/24; - The facility failed to check the NA Registry for CMT N. 2. Review of CMT O's personnel file showed: - Hire date of 01/23/24; - The facility failed to check the NA Registry for CMT O. 3. Review of Licensed Practical Nurse (LPN) P's personnel filed showed: - Hire date of 9/24/24; - The facility failed to check the NA Registry for LPN P. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 4:15 P.M., the Administrator and Director of Nursing (DON) said they would expect the NA Registry to be completed on all new hires prior to their start date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555 Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility) assessment for one resident (Resident #63) out of 18 sampled residents. The facility's census was 87. Review of the facility's policy titled, MDS 3.0 Completion, dated 2024, showed: - Significant Change in Status Assessment (SCSA) - a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements outlined in Chapter 2 of the 3.0 version Resident Assessment Instrument (RAI) Manual; - A SCSA is required when a resident enrolls in a hospice program or changes hospice providers and remains in the facility, or a resident in the facility receiving hospice services discontinues those services (known as revocation of hospice care) and remains in the facility. Review of the RAI Manual, revised October 2024, showed: - An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident; - An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The Assessment Reference Date (ARD) must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill; - The ARD must be less than or equal to 14 days after the Interdisciplinary Team (IDT)'s determination that the criteria for a significant change in status assessment (SCSA) are met (determination date + 14 calendar days); - The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA were met. 1. Review of Resident #63's medical record showed: - An admitted [DATE] to hospice services; - The facility failed to complete a significant change MDS assessment within 14 days of hospice admission; (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A discharge date of [DATE] from hospice services; - The facility failed to complete a significant change MDS within 14 days of the resident's discharge from hospice services. During an interview on 11/22/24 at 11:10 A.M., the MDS Coordinator said he/she would expect a significant change MDS assessment to be completed any time a resident starts or stops hospice services. During an interview on 11/22/24 at 4:15 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) said they would expect a significant change to be completed any time a resident starts or stops hospice services.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for two residents (Resident #7 and #51) out of 18 sampled residents. The facility's census was 87. Review of the facility's policy titled, MDS 3.0 Completion, dated 2024, showed: - According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity, using the Resident Assessment Instrument (RAI) specified by the state; - Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections; - All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment. Review of the RAI Manual, revised October 2024, showed: - A2105: This item documents the location to which the resident is being discharged at the time of discharge; - A2105: Code 04, Short-Term General Hospital: if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care; - H0300: Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire seven days. 1. Review of Resident #7's medical record showed: - An admitted [DATE]; - Diagnoses of end stage renal disease (a permanent condition that occurs when the kidneys stop working), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). Review of the resident's progress notes, dated 05/08/24, showed: - At 3:18 A.M., Resident was transferred to the hospital for further evaluation; - At 5:43 P.M., Resident was admitted with end stage kidney disease and was monitored for uncontrolled pain. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Discharge Return Anticipated MDS, dated [DATE], showed: - Item A2105 coded as resident discharged to home; - Facility failed to document the correct discharge location. 2. Review of Resident #51's medical record showed: - An admitted [DATE]; - Diagnoses of obstructive and reflex uropathy (a condition where urine flow is blocked and causes urine to flow backwards into the kidneys), benign prostatic hyperplasia (enlarged prostate-small gland that helps make semen), and urinary retention (difficulty urinating and completely emptying the bladder). Review of the resident's Admission MDS, dated [DATE], showed: - Section H0100, A. Indwelling catheter-Yes; - Section H0300, Urinary Incontinence-3. Always incontinent; - Facility failed to accurately code MDS as H0300 should be coded 9. Not rated if the resident has an indwelling bladder catheter. During an interview on 11/22/24 at 11:10 A.M., the MDS Coordinator said he/she would expect MDS assessments to be completed accurately and to reflect the current condition of the resident. During an interview on 11/22/24 at 4:15 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) said they would expect MDS assessments to be completed accurately and to reflect the current condition of the resident. 49754

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46460 Based on observation, interview, and record review, the facility failed to follow physician orders for two residents (Resident #8 and #25) out of 18 sampled residents. The facility's census was 87. The facility did not provide a policy related to physician orders. 1. Review of Resident #8's medical record showed: - admitted on [DATE]; - Diagnoses of dementia (thinking and social symptoms that interfere with daily function), hypertension (high blood pressure), and depression (low mood). Review of the resident's Physician Order Sheet (POS), dated 09/05/24, showed an order for weekly weights every day shift every Wednesday for monitoring. Re-weigh if greater than five-pound difference from previous weight. Notify Assistant Director of Nursing (ADON)/Medical Doctor (MD) if a weight loss or gain, start date 9/11/24. Review of the resident's weights summary, dated September 2024- November 2024, showed: - For September 2024, three out of three missed opportunities for weekly weights; - For October 2024, one out of five missed opportunities for weekly weights; - For November 2024, one out of two missed opportunities for weekly weights. 2. Review of Resident #25's record medical showed: - admitted on [DATE]; - Diagnoses of hypothyroidism (the thyroid doesn't produce enough thyroid hormone), chronic obstructive pulmonary disorder (COPD - a debilitating, progressive lung disease), major depressive disorder (low mood), and heart failure (heart does not pump correctly). Review of the resident's POS, dated 07/11/24, showed an order for weekly weights every day shift every Wednesday for monitoring. Re-weigh if greater than five-pound difference from previous weight. Notify ADON/MD if a weight loss or gain, start date 07/17/24. Review of the resident's weights summary, dated July 2024- November 2024, showed: - For August 2024, four out of four missed opportunities for weekly weights; - For September 2024, three out of four missed opportunities for weekly weights; - For October 2024, one out of five missed opportunities for weekly weights; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- For November 2024, two out of two missed opportunities for weekly weights. During an interview on 11/22/24 at 11:08 A.M., Registered Nurse (RN) C said the aides on the hall are responsible for completing the weights of the residents. The night shift will check to see which residents need morning weights, and they will mark it, so the day shift knows who needs weighed. The aides will weigh the residents who need them as they get them up for the day. During an interview on 11/22/24 at 1:40 P.M., Certified Nurse Aide (CNA) D said they get a sheet from the nurse's station that tells them who on their shift needs to be weighed. They try to ensure weights are completed before 6:00 P.M. each day. They will fill out a sheet and give it to the charge nurse. If the resident refuses to be weighed, they will try throughout the day to get them to comply. If they continue to refuse, they will have them sign a refusal and he/she will give it to the charge nurse. During an interview on 11/22/24 at 4:15 P.M., the Administrator, Director of Nursing (DON), and ADON said they would expect physician orders to be followed by the staff. 46555

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 49754 Based on interview and closed record review, the facility failed to complete a comprehensive discharge summary for one resident (Resident #89) out of one sampled closed discharge record. The facility's census was 87. Review of the facility's policy titled, Discharge Summary, undated, showed: - It is the policy of this facility to ensure that a discharge summary is provided upon a resident's discharge which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies; - Upon discharge of a resident (other than in emergency to hospital or death) a discharge summary will be provided to the receiving care provider at the time the resident leaves the facility; - The discharge summary should include: A recapitulation of the resident's stay that includes, but is not limited to: diagnosis, course of illnesses/treatment or therapy, and pertinent lab, radiology, and consultations results, including any pending lab results. A final summary of the resident's status which includes items from the resident's most recent comprehensive assessment; - In addition to the information above, the facility must convey the information to the receiving provider when a resident is discharged (or transferred) from that facility; - Reconciliation of all pre-discharge medications with the resident's post discharge medications to include prescription and over the counter medications; - A post-discharge plan of care that is developed with the participation of the resident, and with the resident's consent, the resident's representative. The post-discharge plan of action must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care, and any post-discharge medical and non-medical services; - For residents discharged to their home, the medical record should contain documentation that written discharge instructions were given to the resident and if applicable, the resident's representative. Review of Resident #89's medical record showed: - Resident discharged to home on 10/07/24; - No recapitulation of the resident's stay including diagnoses, course of illness/treatment, therapy, pertinent labs, radiology and consultation results; - No reconciliation of all pre-discharge medications with the resident's post-discharge medications; (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No post-discharge plan of care developed to assist the resident to adjust to his/her living environment. During an interview on 11/21/24 at 3:15 P.M., the Assistant Director of Nursing (ADON) said he/she looked through the computer and was unable to find a recapitulation of stay, any discharge summary, or discharge notes. There should be a recapitulation of stay and a note stating the resident was discharged on the day of discharge, what time the discharge was, and if the resident was discharged with medications and services and who the resident discharged with. During an interview on 11/22/24 at 4:15 P.M., the Administrator and Director of Nursing (DON) said they would expect a recapitulation of stay, discharge summary, and discharge notes to be completed when a resident is discharged from the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46555 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These practices had the potential to affect all residents who are served food from the kitchen. The facility's census was 87. Review of the facility's policy titled, Use of Plastic Gloves, undated, showed: - REMEMBER GLOVES ARE JUST LIKE HANDS. THEY GET SOILED. ANYTIME A CONTAMINATED SURFACE IS TOUCHED, THE GLOVES MUST BE CHANGED: after coughing or sneezing into hands; touching hair or face; after handling garbage or garbage cans; after handling anything soiled; after handling boxes, crates or packages; after picking up any item off the floor; and any time you touch any contaminated surface. Review of the facility's policy titled, Food Storage, undated, showed foods should be covered, labeled, and dated. Review of the facility's policy titled, Food Temperatures, undated, showed all cold food items must be served to the resident at a temperature of 40 degrees or below at the time the resident receives the food. 1. Observation on 11/19/24 at 1:50 P.M. of the noon meal test tray showed the cheesecake had a temperature of 64 degrees. 2. Observation on 11/19/24 at 2:52 P.M. of the single-door freezer located next to the fryer showed: - A dated gallon-size food storage bag labeled as french fries, unsealed; - A dated gallon-size food storage bag labeled as okra, unsealed; - A dated gallon-size food storage bag labeled as chicken strips, unsealed. 3. Observation on 11/19/24 at 2:50 P.M. and on 11/22/24 at 9:30 A.M. showed a box of corn starch with lid to the box opened and the inner bag opened, with no date on the box. 4. Observation on 11/22/24 at 11:46 A.M. of the Dietary Manager (DM) preparing plates of food for the noon meal showed the DM touched the scoops, plates, and bowls, and then touched sliced cheese and buns while wearing the same gloves three different times during the observation. During an interview on 11/22/24 at 1:38 P.M., the DM said he/she would expect opened food items to be sealed in dated and labeled packages. He/She would expect cold food items to be served at temperatures below 41 degrees and would expect gloves to be changed every time staff touch a dirty surface before touching food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 4:15 P.M., the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) said they would expect food to be properly stored in sealed, dated and labeled packages, gloves to be changed after touching dirty surfaces, and cold food items to be served at below 41 degrees.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46460 Based on interview and record review, the facility failed to maintain quarterly Quality Assessment and Assurance/Quality Assurance Performance Improvement (QAA/QAPI) committee meetings with the required members. The facility's census was 87. Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI), dated 2024, showed: - The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan; - The QAA Committee shall be interdisciplinary and shall consist of a minimum of the Director of Nursing Services; the Medical Director or his/her designee; at least three other members of this facility's staff, at least one of which must be the Administrator, Owner, a Board Member or other individual in a leadership role; and the Infection Preventionist; - Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary. Review of the facility's QAPI Plan, dated January 2024, showed: - The Administrator and/or designated person will be in charge of this home's Quality Assurance Performance Improvement program; - The Quality Assurance Committee is composed of but not limited to: Department Managers, Medical Director, Pharmacy Consultant, interested stakeholders, residents, and families. Review of the QAPI meeting sign in sheets for the past 12 months provided by the Administrator showed: - A sign in sheet incorrectly dated 11/29/24. The Administrator and Medical Director did not attend; - A sign in sheet dated 02/01/24. The Administrator and Medical Director did not attend; - An undated sign in sheet. The Medical Director and Infection Preventionist did not attend. During an interview on 11/22/24 at 2:55 P.M., the Administrator said the Medical Director is invited to meetings and came to one in July. The sign in sheet dated 11/29/24 should be 11/29/23. She does feel like good things come from the meetings, even if they aren't done the way she would do them. She would expect QAPI meetings to be held quarterly. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 4:15 P.M., the Administrator said she would expect the required members, such as the Medical Director, Administrator, Director of Nursing, and Infection Preventionist to be present at all QAPI meetings.

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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** 46460 Based on observation, interview, and record review, the facility failed to maintain infection control practices to prevent the development and transmission of infection during peri care (washing the genital and anal areas of the body) for two residents (Resident #26 and #74) outside of the 18 sampled residents. The facility failed to implement enhanced barrier precautions (EBP) for four residents (Resident #6, #42, #48, and #51) out of 18 sampled residents when they did not follow their policy and ensure proper signage and ensure staff were trained to wear appropriate PPE and ensure PPE was available outside or near the rooms of those residents on EBP. The facility failed to wear proper personal protective equipment (PPE) during wound care and catheter (a flexible tube that drains urine from the bladder and into a bag) care for two residents (Resident #6 and #42) out of 18 sampled residents. The facility's census was 87. Review of the Centers for Medicare & Medicaid Services (CMS) memorandum QSO-24-08-NH, dated 03/20/24, showed: - CMS is issuing new guidance for State Survey Agencies and long term care (LTC) facilities on the use of enhanced barrier precautions (EBP) to align with nationally accepted standards; - EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status; - The new guidance related to EBP is being incorporated into F880 Infection Prevention and Control; - EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities; - EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing; - EBP are indicated for residents with any of the following: Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; - EBP should be used for any residents who meet the above criteria, wherever they reside in the facility; - For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing. (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 facility's policy titled, Enhanced Barrier Precautions, dated 2022, showed: - It is the policy of this facility to implement enhanced barrier precautions (EBP) for the prevention of transmission of MDRO; - EBP refers to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices); - Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves; - An order for EBP will be obtained for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO; - Make gowns and gloves available immediately outside of the resident's room; - Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room); - Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room; - The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education; - High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting; device care or use (central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes), and wound care; - EBP should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. Review of the facility's policy titled, Hand Hygiene, dated 2024, showed: - All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility; - The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. Review of the facility's policy titled, Perineal Care, dated 2024, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Perineal care refers to the care of the external genitalia and the anal area; - Perform hand hygiene and put on gloves. Apply other PPE as appropriate; - Cleanse buttocks and anus, front to back; vagina to anus in females, scrotum to anus in males, using a separate washcloth or wipes; - Change gloves if soiled and continue with perineal care; - Remove gloves and discard. Perform hand hygiene. Review of the facility's policy titled, Catheter Care, dated 2023, showed: - It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care; - Perform hand hygiene; - [NAME] gloves; - The policy did not address wearing a gown for EBP. 1. Observation on 11/21/24 at 8:34 A.M. of wound care for Resident #6 showed: - Licensed Practical Nurse (LPN) J gathered supplies outside the resident's room prior to entering; - LPN J washed hands and donned clean gloves; - LPN J applied wound powder to resident's heel wound per orders; - LPN J removed soiled gloves and washed hands; - LPN J donned new gloves, covered up resident, threw away trash, disposed of soiled gloves, and washed hands; - LPN J did not wear a gown for the duration of wound care; - Resident #6 did not have an EBP sign on his/her door or EBP supplies available outside or near his/her door. During an interview on 11/22/24 at 12:30 P.M., LPN J said he/she would wear gloves to do wound care if the patient was not on isolation. If on contact isolation, then he/she would wear a gown and gloves to perform wound care. 2. Observation on 11/22/24 at 9:00 A.M. of peri care for Resident #74 showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Certified Nurse Assistant (CNA) E did not sanitize or wash his/her hands, donned gloves and assisted the resident with transferring from his/her wheelchair to the toilet; - CNA E removed two plastic liners from his/her pocket and then removed the resident's wet pants and soiled brief; - CNA E placed the wet pants in one plastic liner and the soiled brief in the other plastic liner; - CNA E removed gloves, and did not sanitize or wash hands; -CNA E then placed a clean brief and pants on the resident and left both lying around the resident's ankles on the floor; - CNA E left the resident's room and stood outside of the door to give the resident some privacy; - CNA E reentered the resident's room and donned gloves without washing or sanitizing and assisted the resident to stand; - CNA E retrieved toilet paper from the toilet paper holder and proceeded to wipe feces from a bowel movement from front to back; - With the same soiled gloves, CNA E retrieved toilet paper and wiped bowel movement four more times; - While wearing the same soiled gloves, CNA E wiped the front peri area of the resident twice; - While wearing the same soiled gloves, CNA E pulled up the resident's clean brief and clean pants and assisted the resident to his/her wheelchair; - CNA E removed his/her gloves and washed his/her hands; - CNA E assisted the resident from his/her wheelchair to his/her recliner; - CNA E took a bag of trash to the spa room for disposal and washed his/her hands. During an interview on 11/22/23 at 9:30 A.M., CNA E said he/she would change gloves from dirty to clean and when soiled. He/She would take off his/her gloves when transferring someone or getting them what they need. He/She would wash his/her hands all the time, even if not soiled but especially between dirty and clean. 3. Observation on 11/22/24 at 9:45 A.M. of peri care for Resident #26 showed: - CNA F and CNA G washed hands in the resident's bathroom; - CNA G donned gloves, put supplies on a barrier on the resident's bed, then removed gloves, washed hands and donned new gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- With the resident lying on his/her back on a mechanical lift sling with a washable bed pad underneath, CNA F and CNA G pulled the resident's pants, which had a softball-sized wet spot on the left buttock, down to his/her ankles and unfastened the brief, exposing the resident's peri area; - CNA G cleaned the resident's peri area with a wet disposable wipe, put the used wipe into the soiled brief, then rolled the resident toward him/her with the same soiled gloves, touching the resident's skin with the gloves; - CNA F wiped feces from the resident's buttocks, soiling his/her right glove with fecal material; - CNA F removed gloves and disposed of them into the trash bag on the bed and donned new gloves without performing hand hygiene; - CNA G, wearing the same soiled gloves, rolled the resident onto his/her back and wiped the resident's peri area with a dry wipe and then changed gloves without performing hand hygiene; - CNA F and CNA G removed the soiled brief and, without changing gloves or performing hand hygiene, placed a clean brief on the resident, and pulled the resident's pants up; - CNA F removed gloves, and tied up the bag containing soiled brief and wipes; - CNA F and CNA G transferred the resident to the wheelchair with the mechanical lift; - CNA G removed gloves and washed hands; - CNA F carried the soiled bag in his/her bare hands while obtaining the resident's blanket from the closet; - CNA F set the bag containing the soiled items on a chair in the resident's room and covered the resident with the blanket; - CNA F washed hands, returned the mechanical lift down the hall, took the bag of soiled items to the spa room, and washed hands in the spa room. During an interview on 11/22/24 at 1:30 P.M., CNA F said he/she would perform hand hygiene before providing care, after front care, before back care, and when gloves are soiled. He/She would wear gloves when providing care for a resident with a wound or catheter. During an interview on 11/22/24 at 1:37 P.M., CNA G said he/she would wear gloves with a catheter unless they have an infection, then we should wear a gown. For a resident with wounds, it depends on the kind of wound. If a resident is on isolation, we would wear a gown. He/She would perform hand hygiene before care, after care, and with glove changes. That's something we didn't do with Resident #26 because we were hurrying through, but we did wash our hands before and after. 4. Observation on 11/22/24 at 9:45 A.M. of catheter care for Resident #6 showed: - CNA L and CNA M washed hands and donned gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA L positioned the resident for catheter care and placed a privacy sheet over the resident; - CNA L wiped the resident down the middle, as she verbally stated aloud, while the resident was covered with the 'privacy sheet; - CNA L got a clean wipe, wiped resident down the left side, disposed of cloth, got a new cloth, wiped resident down the right side, disposed of cloth, while resident was covered with the privacy sheet; - CNA L removed gloves, washed hands, donned new gloves, rolled resident to his/her right side, wiped resident's buttocks down the center with clean wipe, wiped right side of resident's buttock, removed gloves, washed hands and donned new gloves; - CNA L placed a new bed pad on the bed; - CNA M removed the old bed pad, bagged up trash and soiled linens, removed gloves, washed hands, and donned new gloves; - CNA L and CNA M covered the resident back up, washed hands and took trash to soiled hold room; - Neither CNA L nor CNA M wore a gown for the entire duration of catheter care; - Resident #6 did not have an EBP sign on his/her door or EBP supplies available outside or near his/her door. 5. Observation on 11/22/24 at 10:40 A.M. of catheter care for Resident #42 showed: - CMT H and CNA I washed hands and donned gloves; - CMT H turned on the bathroom faucet, and CMT H and CNA I got supplies out of the cabinet next to the sink; - CMT H removed gloves and washed hands; - CMT H and CNA I positioned the resident for catheter care; - CMT H wiped once around the catheter insertion site, removed gloves, washed hands, and donned new gloves; - CMT H attempted to wipe again, but the resident grimaced, so CMT H handed the wipe to CNA I, who wiped once around the catheter insertion site, folded the wipe and wiped around the catheter insertion site again, and then with a new wipe, CNA I cleaned the catheter from the insertion site to four inches down the tubing; - CMT H removed gloves, washed hands, and donned new gloves; - CNA I removed gloves and sanitized hands using the sanitizer on the wall in the hallway right outside the resident's room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CMT H disposed of trash in the spa room and washed hands; - Neither CMT H nor CNA I wore a gown for the entire duration of catheter care; - Resident #42 did not have an EBP sign on his/her door or EBP supplies available outside or near his/her door. During an interview on 11/22/24 at 1:33 P.M., CNA I said he/she would perform hand hygiene before providing care, when changing gloves, and when leaving the room. He/She would wear only gloves when providing care for someone with a wound or catheter. During an interview on 11/22/24 at 9:02 A.M., Resident #42 said when staff perform catheter care they wear gloves and a mask, but do not wear a gown. 6. Review of Resident #51's medical record showed: - An admitted [DATE]; - Diagnoses of obstructive and reflex uropathy (a condition where urine flow is blocked and causes urine to flow backwards into the kidneys), benign prostatic hyperplasia (enlarged prostate-small gland that helps make semen), and urinary retention (difficulty urinating and completely emptying the bladder), which requires him/her to have an indwelling urinary catheter; - An order for foley catheter care and maintenance, dated 10/15/24. Observations on 11/21/24 from 8:30 A.M. to 4:00 P.M. and 11/22/24 from 8:30 A.M. to 4:00 P.M. showed: -Resident #51 did not have an EBP sign on his/her door or EBP supplies available outside or near his/her door. During an interview on 11/21/24 at 2:50 P.M., Resident #51 said that staff do not wear gowns when providing care, they only wear gloves. 7. During an interview on 11/21/24 at 3:00 P.M., Resident #48 said staff wear gloves, but do not wear a gown when they perform catheter care. The resident's room and door had no sign or supplies indicating EBP were needed for care. During an interview on 11/21/24 at 3:07 P.M., CNA K said he/she would wear gloves going into a room to do catheter care. During an interview on 11/22/24 at 08:30 A.M., the Infection Preventionist (IP) said anyone with an MDRO, wounds or indwelling devices, like a catheter, are on EBP. The only indwelling devices they have in the building are catheters. Everyone on EBP should have a sign on the door and supplies outside the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/22/24 at 1:50 P.M., the IP said for wound care, staff should wear a gown and gloves if there is an infection. If no wound infection, staff should only wear gloves. For peri-care and catheter care, staff should only wear gloves. As long as staff are not going to get in direct contact with the source of infection, they just wear gloves. If a wound is covered and the dressing is clean, dry, and intact, when performing normal ADLs, staff would wear only gloves. For a new resident on EBP, like a new MDRO on an incontinent resident, there would be a note on the door to see the nurse. The CNAs are really good about communicating. During an interview on 11/22/24 at 4:15 P.M., the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) said they would expect staff to wear the proper PPE (gown and gloves) for residents who are on EBP, such as residents with indwelling medical devices, including catheters and residents with wounds and they would expect gloves to be changed and hands washed when going from dirty to clean. 46555 49754 49879