STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265418	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dixon Nursing & Rehab	403 East 10th Street Dixon, MO 65459

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 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. 42815 Based on interview and record review, facility staff failed to document they administer one resident (Residents #1) medication out of three sampled residents on the residents Medication Administration Record (MAR). The facility census was 29. 1. Review of the facility's policy titled, Physician Orders, undated, showed it did not contain direction for documentation of medication administration. 2. Review of Resident #1's Discharge Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/01/24, showed staff assessed the resident as cognitively intact and did not contain documentation the resident used a bowel toileting program. Review of the residents Physician Order Summary (POS), dated 08/18/24, showed a physician order directed staff to adminster Milk of Magnesia 30 milliliter (ml) if the did not have a bowel movement in three days. Review of the resident's MAR, dated 09/01/24 through 09/30/24, showed staff did not administered Milk of Magnesia between the dates of 09/20/24 through 09/27/24. Review of the facility's bowel movement assessment sheet, dated 9/1/24 to 9/30/24, showed the resident did not have a bowel movement from 09/20/24 through 09/28/24. Review of the resident's medical record, dated 09/28/24, showed staff documented the resident had not had a bowel movement since 09/20/24 and the hospice nurse asked the facility charge nurse to administered a suppository. During an interview on 10/04/24 at 1:45 P.M., Licensed Practical Nurse (LPN) A said staff are directed to follow physician orders. He/She said staff documented bowel movements every shift and the information populated in the nurses electronic MAR, which are checked daily. During an interview on 10/04/24 at 2:34 P.M., Certified Nursing Assistant (CNA) B said staff are directed to document bowel movements in the resident's medical record. He/She said if a resident did not have a bowel movement during the shift, staff are to report to the nurse. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/07/24 at 10:49 A.M., the MDS Coordinator said staff are expected to follow physician orders. He/She said the resident did have an order to provide Milk of Magnesia if he/she did not have a bowel movement in three plus days. He/She staff should have provided Milk of Magnesia after three days. He/She said staff should have contacted the physician if the interventions did not work. The MDS Coordinator said he/she did not know why staff did not follow the physician orders. He/She said he/she did not know if there was an audit in place to ensure staff are following physician orders. He/She said staff pulled a daily bowel movement report. He/She said the nurse should have reviewed the record and directed the Certified Medical Technician (CMT) to follow bowel protocol. He/She said the Director of Nursing (DON) would be responsible to ensure the daily reports were printed and reviewed. During an interview on 10/07/24 at 11:19 A.M., the administrator said staff are required to follow physician orders. He/She said the aides documented bowel movements in the resident's medical chart every shift as it occurred. He/She said if the resident did not have a bowel movement for three days, staff should assess the resident. He/She said if there was an order for a medication to be administered after three days without a bowel movement, staff would administer. He/She said the nighttime charge nurse was responsible for printing out the bowel movement report daily. He/She said the day charge nurse would review the report and communicate with the CMT if a medication needed to be administered, or contact the physician, if the resident needed a new order for a constipation medication. The administrator said he/she did not see any documentation staff had administered medication after the resident did not have a bowel movement for over three days. He/She said there was not a system in place to audit to ensure the bowel movement report were printed and reviewed daily. During an interview on 10/07/24 at 11:19 A.M., the DON said staff are required to follow physician orders. He/She said the aides documented bowel movements in the resident's medical chart every shift as it occurred. He/She said if the resident did not have a bowel movement for three days, staff should assess the resident. He/She said if there was an order for a medication to be administer after three days without a bowel movement, staff would administer. He/She said the night time charge nurse was responsible for printing out the bowel movement report daily. He/She said the day charge nurse would review the report and communicate with the CMT if a medication needed to be administered, or contact the physician, if the resident needed a new order for a constipation medication. He/She said he/she did not see any documentation staff administered medication after the resident did not have a bowel movement for over three days. MO00242841 and MO00242970

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42815 Based on observation, interview, and record review, facility staff failed to use a gait belt to transfer one resident (Resident #1) from his/her bedside commode to chair which resulted in the resident being sent to the hospital with a significant injury. The facility census was 29. The administrator was notified on 10/04/24 of Past Non-Compliance which occurred on 09/28/2024. On 9/28/24 Certified Nurse Aide (CNA) B and CNA C did not use a gait belt to transfer Resident #1 from his/her bedside commode to bed, which resulted in the resident being sent to the hospital with a significant injury. Upon discovery, facility staff investigated the cause of the resident's injury, and in-serviced staff on how to perform a safe transfer of a resident with a gait belt from 09/29/24 through 09/30/24. Staff corrected the deficient practice on 10/02/24. 1. Review of the facility's policy titled, Gait Belt Use, undated, showed the purpose of a gait belt is to provide better control and balance while assisting resident with ambulation and transfer. 2. Review of Resident #1's Discharge Minimum Data Set (MDS), a federally mandated assessment tool, dated 08/01/24, showed staff assessed the resident as cognitively intact, required substantial to maximal assistance from staff with transfers to and from a bed to a chair or wheelchair, and non-weight bearing. Review of the facility's investigation, undated, showed staff documented CNA B documented he/she transferred the resident from his/her bedside commode to the bed when the resident's leg gave out and staff lowered him/her to the floor. Review showed CNA C documented he/she assisted CNA B with transferring the resident from his/her bedside commode to the bed when CNA B said he/she heard and felt a creek, then lowered the resident to the floor. Review of the facility in-service, dated 09/29/24 through 09/30/24, showed staff had been educated to use a gait belt for all residents who required assistance with transfers and/or ambulation. Review of the resident's medical record, dated 09/28/24, showed staff documented the resident had been transferred from his/her bedside commode to his/her bed. Staff said when they stood the resident up, the resident was unable to support himself/herself with his/her leg and staff sat the resident on the floor. Review showed staff documented they heard and felt a popping noise in the resident's left shoulder. The resident had to be transferred to the hospital. Review of the facility's In-service training record, dated 09/29/24 through 09/30/21, showed staff received education on gait belt use. The record showed staff are to use a gait belt when a resident requires assistance with transfers and/or ambulation. During an interview on 10/04/24 at 1:45 P.M., Licensed Practical Nurse (LPN) A said staff are required to use a gait belt when transferring a resident who is non weight bearing. He/She said the resident is non-weight bearing. The LPN said if the resident refused to allow staff to use a gait belt during a transfer, staff should have reported the refusal to the charge nurse, who could have re-approached and explained the risk of transferring without a gait belt. He/She said if staff does not safely transfer a resident with a gait belt, there is the potential for injury to the resident or staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/04/24 at 2:07 P.M., CNA B said he/she and CNA C transferred the resident from the commode to the bed, when the resident's leg went out from under him/her and he/she started to fall. CNA B said staff caught the resident by his/her arm and he/she heard a popping noise. The CNA said the resident refused to use a gait belt during transfers in the past, so he/she did not use one. He/She said he/she did not know what he/she should have done if the resident refused to use a gait belt, but he/she will report a resident's refusal to the nurse in the future. CNA B said he/she had been in-serviced on how to perform a proper transfer, to include the use of a gait belt between 9/29/24 and 9/30/24. During an interview on 10/04/24 at 2:43 P.M., CNA C said he/she went in to assist the other staff transfer the resident from the commode to the bed. The CNA said staff did not have a gait belt placed around the resident when he/she entered the room. He/She said the resident lifted his/her one leg off the floor and began to fall when staff caught him/her by his/her arms. The CNA said staff should have used a gait belt during the transfer. He/She said it was unsafe to transfer the resident without a gait belt. He/She said he/she should have not allowed the staff to continue with the unsafe transfer, but did not think about it at the time. During an interview on 10/07/24 at 10:49 A.M., the MDS Coordinator said CNA B reported to him/her they transferred the resident from the bedside commode to his/her bed, when the resident's leg became weak and staff lowered him/her to the floor. He/She said staff told him/her they did not use a gait belt and were holding the resident under his/her arms. He/She said the aide told him/her he/she felt and heard a popping noise from the resident's shoulder area. The MDS Coordinator said the resident required two person assistance from staff for transferring, which included the use of a gait belt or a mechanical lift. He/She said he/she reported the incident to the administrator and Director of Nursing (DON). During an interview on 10/07/24 at 11:19 A.M., the administrator said staff are directed to use a gait belt if the resident is unable to ambulate or transfer without staff assistance. He/She said he/she was told staff were assisting the resident to the bedside commode when the resident's leg became weak during the transfer and staff lowered him/her to the floor. He/She said staff placed their hands under the resident's arm when transferring the resident from the commode to his/her bed and did not use a gait belt. He/She said staff heard a pop in the resident's left shoulder area. He/She said CNA B notified the charge nurse and MDS Coordinator. He/She said the nurse assessed the resident and did not see any deformities, but did have complaints of pain. He/She said the resident was transferred to the hospital. He/She said staff conducted an in-service upon discovering the staff did not use a gait belt during the transfer of the resident. During an interview on 10/07/24 at 11:20 A.M., the DON said staff are directed to use a gait belt if the resident is unable to ambulate or transfer without staff assistance. He/She said he/she was told staff were assisting the resident to the bedside commode when the resident's leg became weak during the transfer and staff lowered him/her to the floor. He/She said staff placed their hands under the resident's arm when transferring the resident from the commode to his/her bed and did not use a gait belt. He/She said staff heard a pop in the resident's left shoulder area. He/She said CNA B notified the charge nurse and MDS Coordinator. He/She said the nurse assessed the resident and did not see any deformities, but did complaints of pain. He/She said the resident was transferred to the hospital. He/She said staff conducted an in-service upon discovering the staff did not use a gait belt during the transfer of the resident. (continued on next page)

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