| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265428 | A. Building<br>B. Wing | 02/25/2025 |

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| Lebanon South Nursing & Rehab | 514 West Fremont Road<br>Lebanon, MO 65536 |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787<br><br>Based on interview and record review, the facility failed to provide care in accordance with professional standards when facility staff failed to complete an ordered x-ray and follow-up with the ordering provider for one resident (Resident #1) who had complaints of leg pain and swelling until, three days after the initial order resulting in delayed treatment of a fractured ankle. The facility census was 74.<br><br>Review showed the facility did not provide a policy related to resident change in condition.<br><br>1. Review of the Resident #1's face sheet (brief information sheet about the resident), showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included cerebral infarction (stroke - condition where blood flow is interrupted, causing brain tissue to die), heart failure (chronic condition in which the heart doesn't pump blood as well as it should), disorder of bone density and structure (medical condition where the bones lose mineral density and experience changes in their architectural makeup, leading to weakened bones that are more prone to fractures), and pain.<br><br>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/28/25, showed the following:<br><br>-Cognitively intact;<br><br>-Limited range of motion both lower extremities;<br><br>-Use of walker and wheelchair;<br><br>-Supervision required for transfers to bed, chair, and toilet;<br><br>-Dependent on staff for wheelchair mobility.<br><br>Review of the resident's care plan, last reviewed 12/23/24, showed the following:<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -Resident had pain related to osteoarthritis (degeneration of joint cartilage and the underlying bone, causes pain and stiffness), spinal stenosis (condition where the spinal canal, the bony tunnel that contains the spinal cord and nerve roots, becomes narrowed) and bone density disorder,<br><br>-Resident's pain will be recognized and effectively treated to promote his/her comfort and well-being, lessening symptoms and functional decline;<br><br>-Staff should administer acetaminophen (analgesic drug used to relieve mild or chronic pain) and Aleve (nonsteroidal anti-inflammatory drug (NSAID) that reduces pain) per physician order and monitor for effectiveness;<br><br>-Staff should identify any causative factors and ways to alleviate;<br><br>-Staff should monitor pain every shift and as needed;<br><br>-Staff should offer non-drug interventions such as repositioning, relaxation, increased or decreased active, etc.;<br><br>-Resident had reduced activity of daily living (ADL) functioning related to impaired mobility;<br><br>-Staff should provide standby assist for ADL's to include toileting, bathing, grooming, dressing and eating;<br><br>-Staff should notify physician and responsible party with changes in care as needed.<br><br>Review of the resident's medical record showed the following:<br><br>-A physician order, written on 01/31/25, by nurse practitioner (NP - nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor) for left ankle x-ray (medical imaging technique that uses radiation to create pictures of the inside of the body) three view due to pain and swelling;<br><br>-A note written across the order that stated physician said no.<br><br>Review of the resident's medical record showed staff did not document follow-up with the NP regarding the ordered x-ray and did not document a reason the physician said no.<br><br>Review of the resident's progress notes showed the following:<br><br>-On 02/03/25, at 10:50 A.M., a phone call was received from NP asking about the x-ray of left ankle. The nurse informed the NP that the physician said not to do the x-ray. The NP informed the nurse he/she spoke with the physician and he/she okayed the order and to proceed with the x-ray. Order placed and awaiting mobile x-ray company. Staff will continue with current plan of care;<br><br>-On 02/04/25, at 10:47 A.M., the preliminary results of x-ray showed a tibia and fibula (two long bones in the lower leg that connect the knee to the ankle) fracture determined by NP. NP ordered resident sent to the emergency room . Staff notified the resident's family;<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -On 02/04/25, on 6:00 P.M., the nurse took report from the emergency room nurse. The resident was returning via ambulance. Resident had a fractured left tibia/fibula. The left leg was splinted with long-leg posterior splint with stirrups (device that immobilizes the lower leg and foot to treat injuries to the knee, ankle, and leg) and resident was to be non-weight bearing to left leg. Resident will need follow up with orthopedic (branch of medicine related to bones).<br><br>Review of the resident's emergency room records, dated 02/04/25, showed the following:<br><br>-Patient presented to the emergency room with complaints of left ankle pain and swelling;<br><br>-Patient stated had imaging done at nursing home and had broken ankle in two spots;<br><br>-Patient stated that he/she had not walked in years and pretty much was in a wheelchair;<br><br>-X-ray results showed non-displaced medial malleolus (the inner bony bump on the ankle) fracture and non-displaced fracture of the distal meta-diaphysis (long tubular (long round) mid-portion of bone) of the fibula;<br><br>-Patient placed in a long-leg posterior splint with stirrups.<br><br>During an interview on 02/25/25, at 8:20 A.M., the resident said that he/she had an x-ray of left lower leg because of pain and swelling. The x-ray showed a fracture. He/she did not remember bumping or injuring the leg. This also had happened to his/her right leg about five years ago. He/she said that there was initially mild pain that increased to severe pain for about one week and the NP ordered an x-ray.<br><br>During an interview on 02/25/25, at 12:35 P.M., the resident's Nurse Practitioner said that the resident had complained of leg pain for about one month. He ordered an x-ray and the primary physician denied the x-ray request because of the past history of right leg fracture. The nursing staff did not notify the NP that the x-ray order was not approved or completed. He called several days later for the results and was notified at that time. He contacted the primary physician and discussed that it was the left leg not the right leg and the physician then approved the x-ray. He said that he was not always notified if the orders he recommended were not carried out. He was not notified that the x-ray was not done.<br><br>During an interview on 03/03/25, at 9:20 A.M., the resident's Physician said that all orders have to come through her. She denied the x-ray order because she was not told which leg and the right leg had been x-ray multiple times and it was not necessary to x-ray that leg again. It was a miscommunication and the resident should have gotten the care sooner.<br><br>During an interview on 02/25/25, at 11:10 A.M., Nurse Aide (NA) B said that any time a resident had complaints of new pain or other new symptoms, he/she would immediately notify the charge nurse. If the NA felt the nurse was not evaluating the complaint, the NA would go up the chain of command. The resident rarely complained of pain prior to the recent leg fracture.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 02/25/25, at 12:40 P.M., Certified Nurse Aide (CNA) C said that if a resident had complaints of new pain or other new symptoms, he/she would immediately notify the charge nurse. The resident had no complaints of any injury to his/her leg. He/she went with the resident to the appointment. The resident only complained of pain when standing to transfer.<br><br>During an interview on 02/25/25, at 12:50 P.M., CMT D said that any time a resident had any complaints of pain or other symptoms he/she would immediately notify the charge nurse.<br><br>During an interview on 02/25/25, at 1:10 P.M., Registered Nurse (RN) A said that for any resident change in condition he/she would go assess the resident and note the type of pain, see if the pain was new or chronic and usually document a progress note. The resident had complaints of chronic pain to the right leg and did not complain of left leg pain until the fracture was noted. When the NP provides an order the nurses notify the physician to get approval. This can be frustrating and is more time consuming and may have delayed the resident care due to waiting to get the second order. At the time of the x-ray order for the resident denied the order. The physician was the overall provider for the resident's care plan. Prior to the fracture the resident had chronic pain of the right leg. There was some swelling of the left leg with no significant change or bruising noted on the leg.<br><br>During an interview on 02/25/25, at 1:25 P.M., RN E said that he/she would assess any resident's complaints of new pain or change in health condition. He/she would notify the Assistant Director of Nursing (ADON), Director of Nursing (DON), and the physician.<br><br>During an interview on 02/25/25, at 1:30 P.M., Licensed Practical Nurse (LPN) F said if a resident had complaints of new symptoms, including pain, he/she would notify the charge nurse. He/she completed skin assessments weekly and noted no redness or bruising of the resident's left leg. He/she said that when the NP provided the x-ray order for the resident, he/she texted the primary physician and the physician said not to get the x-ray. He/she was unsure if the nurses notified the NP of the denied x-ray order. The resident complained of increased pain from 01/31/25 to 02/04/25. The x-ray results were received on 02/04/25.<br><br>During an interview on 02/25/25, at 2:05 P.M., the DON said that the nursing staff should notify the physician for orders for any resident complaint of new pain. The nursing staff should notify the NP for any residents under the NP care. They also notify the physician for approval of any orders the NP provided. She was not aware of the x-ray order being denied until after the second x-ray ordered was approved on 02/03/25. She expected the nursing staff to follow the physician orders. She did not know if staff notified the NP that the order was denied. It would be a good idea to notify the NP. The resident had swelling and pain in the left leg. She did not know if the staff notified the physician of that along with the request for left leg x-ray.<br><br>During an interview on 02/25/25, at 2:25 P.M., the Administrator said she expected staff to notify the charge nurse with any new complaints of pain or change in health. The nurse should evaluate and contact the physician and family of new pain or change in health. When the NP provided an order the staff should contact the physician for approval. When the x-ray order for the resident was not completed the staff should have contacted the NP and should have told the Administrator and DON. Any resident change in condition should be discussed in morning meetings.<br><br>MO00249046 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787<br><br>Based on observation, interview, and record review, the facility failed to provide respiratory care per standards of practice when staff failed to ensure oxygen and nebulizer tubing were stored properly when not in use when the nebulizer tubing and mouthpiece was noted to be on the floor and not in protective cover for one resident (Resident #2 ), noted to be on the chair and not in protective covering for one resident (Resident #4), and oxygen nasal cannula (thin, flexible tube that delivers oxygen through the nose) and tubing was on the back of the resident's wheelchair not in a protective bag for one resident (Resident #3) in a common area. The facility census was 74.<br><br>Review of facility policy titled Oxygen Administration, undated, showed the following:<br><br>-Purpose of policy was to administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues;<br><br>-Connect nasal cannula tubing to humidifier outlet and adjust liter flow as ordered;<br><br>-Place prongs of cannula into the resident's nares (nose);<br><br>-Adjust elastic loosely around head above ears;<br><br>-At regular intervals, check and clean oxygen equipment, masks, tubing and cannulas;<br><br>-Place cannula tubing in plastic bag attached to concentrator when tubing is not in use.<br><br>Review of facility policy titled Aerosol Therapy Treatments (medical procedure that involves delivering medications in the form of tiny droplets (aerosols) into the respiratory tract), undated, showed the following:<br><br>-Medication can be given in many forms. One way is to inhale the medication in aerosol form;<br><br>-Staff should gather all equipment needed for the procedure;<br><br>-Remove the top part of the nebulizer cup (small, cup-shaped device that holds liquid medicine that is then turned into a mist);<br><br>-Place medication in the bottom of the nebulizer cup;<br><br>-Attach the top portion of the nebulizer cup and connect the mouthpiece or face mask to the cup;<br><br>-Turn on the compressor;<br><br>-Continue the treatment until all the medication is gone;<br><br>-Turn off the compressor;<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Clean equipment per guidelines after each use.<br><br>1. Review of Resident #2's face sheet (brief information sheet about the resident) showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), chronic respiratory failure (medical condition where the lungs are unable to adequately exchange gases, resulting in low levels of oxygen (hypoxemia) and/or high levels of carbon dioxide (hypercapnia) in the blood) with hypercapnia, and bronchitis (inflammation of the lining of bronchial tubes, which carry air to and from the lungs).<br><br>Review of the resident's care plan, last updated 01/02/25, showed the following:<br><br>-Resident had shortness of breath related to COPD and chronic respiratory failure;<br><br>-Staff should administer oxygen at 2 liters (amount to be delivered through oxygen device) via nasal cannula;<br><br>-Staff should observe oxygen precautions;<br><br>-Staff should administer albuterol via nebulizer and ipratropium-albuterol via nebulizer;<br><br>-Staff should change oxygen tubing weekly and nebulizer tubing per facility protocol.<br><br>Review of the resident's physician orders, active as of 02/25/25, showed the following:<br><br>-An order, dated 12/24/24, for albuterol sulfate solution (used to prevent and treat wheezing and shortness of breath caused by breathing problems) for nebulization: 2.5 milligram (mg)/3 milliliter (ml), one vial inhalation every 4 hours as needed;<br><br>-An order, dated 01/21/25, ipratropium-albuterol solution (combination solution used to help control the symptoms of lung diseases, such as asthma, chronic bronchitis, and emphysema) for nebulization: 0.5 mg-3 mg/3 ml, one vial twice per day with mask;<br><br>-An order, dated 05/04/24, to change nebulizer tubing monthly.<br><br>Observation on 02/25/25, at 8:50 A.M., showed the resident resting in bed with oxygen on by nasal cannula. A nebulizer machine with tubing and mouthpiece attached was setting directly on the floor with the mouthpiece touching the tile with no protective covering.<br><br>2. Review of Resident 3's face sheet showed the following:<br><br>-admitted [DATE];<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Diagnoses included Parkinson's disease (progressive neurological disorder that affects movement, balance, and coordination), bacterial pneumonia (lung infection caused by bacteria), and acute respiratory disease (number of conditions that affect the lungs).<br><br>Review of the resident's care plan, last updated 02/04/25, showed staff did not care plan related to oxygen usage;<br><br>-No information related to use of oxygen.<br><br>Review of the resident's physician orders, active as of 02/25/25, showed the following:<br><br>-Standard wheelchair.<br><br>-No order noted for oxygen.<br><br>Observation on 02/25/25, at 9:00 A.M., showed the resident in the hallway in his/her wheelchair. The resident had his/her eyes closed. There was an oxygen tank on the back of the resident's wheelchair with tubing and nasal cannula attached. The nasal cannula was setting on the back side of the wheelchair exposed to air with no protective covering.<br><br>3. Review of Resident #4's face sheet showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included shortness of breath and cognitive communication deficit.<br><br>Review of the resident's physician orders, active as of 02/25/25, showed an order, dated 11/25/24, for ipratropium-albuterol solution for nebulization; 0.5 mg-3 mg/3 ml; amount to administer: one vial every 6 hours as needed.<br><br>Review of the resident's care plan, last updated 12/16/24, showed staff did not care plan regarding nebulizer use.<br><br>Observation on 02/25/25, at 9:15 A.M., showed the resident in bed with staff in the room for catheter care. There was a nebulizer machine with tubing and mouthpiece attached setting on a bedside chair, with the mouthpiece touching the chair with no protective covering.<br><br>4. During an interview on 02/25/25, at 12:40 P.M., Certified Nurse Aide (CNA) C said when a resident had oxygen or nebulizer tubing that was not in use, the tubing should be in a plastic bag next to the machine to keep the tubing clean until the next use. The tubing, mouthpiece, or nasal cannula should not be touching the floor or open to air.<br><br>During an interview on 02/25/25, at 12:50 P.M., Certified Medication Tech (CMT) D said oxygen and nebulizer tubing should not be on the floor or bedside chair. It should be protected and in a plastic bag when not in use.<br><br>During an interview on 02/25/25, at 1:10 P.M., Registered Nurse (RN) A said oxygen and nebulizer tubing should be covered when not in use and should not be on the floor or in a chair.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 02/25/25, at 1:20 P.M., RN E said oxygen and nebulizer tubing should be in a plastic bag when not in use. The tubing should not be on the floor.<br><br>During an interview on 02/25/25, at 1:29 P.M., Licensed Practical Nurse (LPN) F said oxygen and nebulizer tubing should be in a plastic bag when not in use to keep clean.<br><br>During an interview on 02/25/25, at 2:05 P.M., the Director of Nursing (DON) said oxygen and nebulizer tubing should be in a plastic bag when not in use. The tubing should not be on the floor or exposed to air without protection to keep clean until next use.<br><br>During an interview on 02/25/25, at 2:25 P.M., the Administrator said oxygen and nebulizer tubing should be in a plastic bag when not in use. Tubing should not be on the floor or any other non-clean surface. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787<br><br>Based on observation, record review, and interview, the facility failed to establish and maintain an effective infection prevention and control program when staff failed to educate staff on and implement a process for Enhanced Barrier Protection (EBP - are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) policy and procedure when staff did not wear gowns when completing catheter (a flexible tube that drains urine from the bladder) care for two residents (Resident #2 and #4). The facility census was 74.<br><br>Review of the Centers for Disease Control and Prevention (CDC)'s Considerations for Use in Skilled Nursing Facilities, dated 06/2021, showed the following information:<br><br>-MDRO transmission is common in skilled nursing facilities, contributing to significant morbidity and mortality for residents and increased costs for the health care system;<br><br>-EBP involves gown and glove 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);<br><br>-EBP may be applied (when Contact Precautions do not otherwise apply) to residents with wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;<br><br>-Effective implementation of EBP required staff training on the proper use of personal protective equipment (PPE) and the availability of PPE with hand hygiene products at the point of care;<br><br>-EBP to routine care of residents with wounds or indwelling medical devices requires that staff<br><br>participate in initial and on-going training on the facility ' s expectations about hand hygiene and<br><br>gown and glove use, along with proof of competency regarding appropriate use and donning<br><br>and doffing technique for PPE;<br><br>-Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities;<br><br>-Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room);<br><br>-A trash can (or laundry bin, if applicable) large enough to dispose of multiple gowns should be available for each room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the facility policy titled Enhanced Barrier Precautions to Infection Control Guidance, dated March 2024, showed the following:<br><br>-Purpose to prevent broader transmission of MDROs and to help protect patients with chronic wounds and indwelling devices;<br><br>-EBP should be implemented for the period of the stay or until wounds have resolved or indwelling medical devices have been removed;<br><br>-Resident who are known to be infected or colonized with a MDRO, residents with an indwelling medical device including urinary catheter regardless of their MDRO status, and residents with a wound, regardless of the MDRO status a require EBP;<br><br>-Use EBP when providing high-contact resident care activities such as bathing, transferring resident from one position to another, providing hygiene, changing bed linens, changing briefs or assisting with toileting, caring for or using an indwelling medical device, performing wound care;<br><br>-Conduct proper hand hygiene before starting care;<br><br>-Gloves and donning and doffing of gown are required when conducting high-contact resident care activities;<br><br>-Gloves and gown should be removed and discarded after each resident care encounter;<br><br>-Attempt to arrange cares to be grouped together to assist in reducing consumption of supplies with practical;<br><br>-EBP should be performed when performing transfers or assisting during bathing in a shared/common shower and when working with residents in the therapy gym;<br><br>-Residents that are placed on EBP should have PPE in close proximity outside the door and a trash can in the resident's room for disposal prior to leaving the room;<br><br>-Multi-resident medical equipment must be sanitized between resident uses.<br><br>1. Review of Resident #2's face sheet (brief information sheet about the resident) showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe) and urinary tract infection (bacterial infection of urinary tract, which includes kidneys and bladder).<br><br>Review of the resident's physician orders, active as of 02/25/25, showed the following:<br><br>-An order, dated 12/24/24, for catheter type indwelling, size 16 French (universal sizing system for internal urinary catheters), 10 ml balloon (inflated to hold catheter in place);<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265428 | A. Building<br>B. Wing | 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lebanon South Nursing & Rehab | 514 West Fremont Road<br>Lebanon, MO 65536 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -An order, dated 12/24/24, to change catheter at physician discretion;<br><br>-An order, dated 12/24/24, for catheter care every shift;<br><br>-An order, dated 12/24/24, to change catheter monthly.<br><br>Review of the resident's care plan, last updated 01/02/25, showed the following:<br><br>-Resident had an indwelling urinary catheter;<br><br>-Staff should change catheter per physician orders;<br><br>-Staff should provide catheter care per physician orders.<br><br>(Staff did not care plan related to EBP.)<br><br>Observation on 02/25/25, at 11:00 A.M., showed Certified Nurse Aide (CNA) C entered the resident's room to drain the resident's catheter bag. The CNA applied prepared supplies and applied gloves. The aide opened the drain tip of the catheter bag (opening that allows urine to drain from the catheter into a collection container) and drained the urine into a collection cup. The aide then wiped the drain tip with an alcohol wipe and secured to the catheter bag. The aide disposed of the urine into the toilet and rinsed the container with water. The aide removed his/her gloves and washed hands and left the room. The aide did not apply a gown for EBP. There was no signage regarding EBP use and there was no PPE near the resident's room.<br><br>2. Review of Resident #4's face sheet showed the following:<br><br>-admitted [DATE];<br><br>-Diagnoses included cognitive communication deficit, benign prostatic hyperplasia (non-cancerous enlargement of prostate (gland surrounding the tube that empties the bladder)) with lower urinary tract symptoms (pain or burning when urinating, frequent urination).<br><br>Review of the resident's physician orders, active as of 02/25/25, showed the following:<br><br>-An order, dated 11/25/24, for catheter care every shift;<br><br>-An order, dated 11/25/24, to change catheter monthly;<br><br>-An order, dated 11/25/24, to change catheter as needed;<br><br>-An order, dated 11/25/24, to change catheter at physician discretion;<br><br>-An order, dated 11/25/24, to flush catheter with 30 ml normal saline daily as needed.<br><br>Review of the resident's care plan, last updated 12/16/24, showed the following<br><br>:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Resident had a catheter related to benign prostatic hypertrophy (enlargement);<br><br>-Staff will perform catheter care per physician orders;<br><br>-Staff will report signs of urinary tract infection.<br><br>(Staff did not care plan related to EBP.)<br><br>Observation on 02/25/25, at 9:15 A.M., showed Registered Nurse (RN) A and Licensed Practical Nurse (LPN) F entered the resident's room to change the resident's catheter. The nursing staff prepared supplies and washed their hands at the sink and applied gloves. RN A opened a syringe and removed fluid from the catheter balloon. RN A removed the catheter from the resident's bladder and disposed of the catheter into the trash. RN A removed gloves and washed hands at sink. He/she applied new gloves. LPN F opened the supplies and attached the new catheter tubing to the new catheter bag. RN A attempted to put on sterile gloves and the gloves were too small and caused the gloves to tear. The nurses removed gloves and washed hands at the sink. RN A left the room to find another nurse with smaller hands. RN A returned with supplies and asked LPN F to try the catheter change. LPN F washed hands at sink and attempted to put on sterile gloves and the gloves tore. He/she removed the gloves and washed hands at sink. The staff covered the resident and left the room to find another nurse. The staff did not apply gowns for EBP.<br><br>Observation on 02/25/25, at 9:55 A.M., showed RN E entered the resident's room with supplies and disinfected the bedside table, prepared supplies on the table, and then washed his/her hands at the sink. He/she opened the sterile glove package and applied the gloves. The nurse cleaned the resident's private region appropriately for catheter care, attempted to insert the catheter tubing and it would not advance. The nurse removed the catheter tubing. Covered the resident and disposed of supplies, removed gloves, and washed hands at the sink. The nurse left the room and notified the charge nurse, who notified the physician and advised to send the resident to the emergency room for catheter insertion. The nurse did not apply a gown for EBP. There was no signage regarding EBP use and there was no PPE near the resident's room.<br><br>4. During an interview on 02/25/25, at 11:10 A.M., Nurse Aide (NA) B said that when preparing a resident for catheter care he/she would wash hands and apply gloves. After completing the resident care, he/she would remove gloves and wash his/her hands. He/she said that EBP included the use of barrier creams to protect resident skin. He/she said that use of gowns was for residents that were on contact precautions, such as when a resident had an infection. The nurses notify the staff when to use PPE and sometimes there were signs and PPE carts near the residents' rooms. He/she did not wear a gown to complete catheter care or toileting hygiene with a resident that had a wound.<br><br>During an interview on 02/25/25, at 12:40 P.M., CNA C said that he/she had not heard of EBP. He/she said that when working with residents he/she was required to wear a gown, gloves, and sometimes a mask if a resident had the flu. There were no signs related to EBP and no PPE near any resident rooms at this time.<br><br>During an interview on 02/25/25, at 12:50 P.M., Certified Medication Tech (CMT) D said that he/she had not heard of EBP. He/she said that if a resident had flu or COVID then he/she would wear a gown and gloves in a resident room. The nurse would tell him/her when this was required.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 02/25/25, at 1:10 P.M., Registered Nurse (RN) A said he/she had not received any training about EBP. He/she only wore a gown in a resident room if the resident was on isolation or if there were specific organism present in a resident wound.<br><br>During an interview on 02/25/25, at 1:20 P.M., RN E said that he/she had EBP training at a previous place of employment. He/she was aware that EBP included a resident that had any type of tube or open area. Staff should wear a gown, gloves, and sometimes masks when completing resident cares. He/she said that the staff at the facility were not using EBP.<br><br>During an interview on 02/25/25, at 1:29 P.M., Licensed Practical Nurse (LPN) F said if there was a substantial wound when completing wound care then he/she would need to use EBP. Generally, he/she did not use gown when completing wound care. The PPE could be found in the supply closet, but it was not readily available at resident rooms.<br><br>During an interview on 02/25/25, at 2:05 P.M., Director of Nursing (DON) said if residents that had wounds or indwelling devices that were leaking, staff should wear a gown and gloves. She was not aware that gowns should be worn any time direct resident care completed with residents with chronic wounds or indwelling devices. PPE was available in all storage room. She did not think that staff needed to wear a gown if the wound was covered when completing personal cares.<br><br>During an interview on 02/25/25, at 2:25 P.M., the Administrator said that with residents with catheters, wounds, or indwelling medical devices, staff should wear gloves when completing direct cares. Gowns are used if a resident was on isolation precautions. EBP was used when residents were higher risk and usually have PPE out by the resident door at that time. The facility just got all resident off isolation precautions recently. He/she was not aware that gowns and gloves should be used for EBP with high-contact care of residents with chronic wounds and indwelling medical devices regardless of MDRO status. |