STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265504	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Current River Nursing Center, Inc	1015 North Grand Avenue Doniphan, MO 63935

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 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. This had the potential to affect all residents. The facility census was 42.Review of the facility's policy titled, Cleaning Schedule, undated, showed: - Equipment and utensils will be cleaned according to the following guidelines, or manufacturer's instructions: Items cleaned after each use include can opener, small food preparation equipment (e.g. blender, food processor), slicer, kettles, utensils, mixers, cutting boards, worktables, counters, beverage table, coffee urns, pots and pans, dishes, dining room tables and chairs; Items cleaned daily include stove top, grill, kitchen and dining room floors, kitchen towels and cloths, toaster, microwave oven, mop and buckets, steam table, hand washing sink, food carts, pot and pan sink, and exterior of large appliances; Items cleaned weekly include hoods, filters, trash barrels, garbage disposals, coffee machine, storerooms, drawers, cleaning closet, shelves, ovens, and cupboards; Items cleaned monthly include refrigerators, freezers, ingredient bins, ice machines, food containers, and walls; Items cleaned annually include ceilings and windows.Review of the facility's Daily Cleaning Schedule, dated August 2025, showed:- Counter tops, steam table, blender/food processor, toaster, and refrigerator cleaned on 08/25/25;- Counter tops, steam table, blender/food processor, toaster, and refrigerator not cleaned on 08/01/25 - 08/24/25, with 24 missed opportunities out of 25 opportunities.Review of the facility's Weekly Cleaning Schedule, dated August 2025, showed:- Hoods, filters, trash barrels, garbage disposals, coffee machine, storerooms, drawers, cleaning closet, shelves, ovens, and cupboards not cleaned for 08/01/25 - 08/24/25, with three missed opportunities out of three opportunities.1. Observations on 08/26/25 at 9:35 A.M., and 12:15 P.M., 08/27/25 at 2:00 P.M., and 8/28/25 at 12:15 P.M., of the kitchen showed:- The center reach-in refrigerator did not function;- A plate warmer did not function;- A window unit air-conditioner with a brown build up on the ventilation louvers;- The ice machine with a white grime build up on the exterior surfaces and interior plastic surface, the ventilation louvers with a brown substance, three plastic drain lines with black grime build up and no air gap drained into a 4 inch (in.) unglued floor drain with a black grime build up; - The dishwasher with white grime build-up on the exterior surfaces;- An approximate 24 in. x 24 in. ceiling diffuser (one of the few visible parts of an air conditioning system) with dust buildup and a brown substance on the front exterior surface and in between the ventilation louvers;- An approximate 12 in. x 12 in. ceiling diffuser with dust buildup and a brown substance in the dry storage area;- Three undated and unlabeled partially full five-gallon clear plastic storage bins with sugar, salt, and oatmeal;- An unidentified dietary aide dipped food from the steam table trays onto plates with a facial hair restraint partially in place; - A refrigeration repairman worked on the reach-in refrigerator during meal preparation without a hair restraint; - A repair mechanic worked on the coffee machine during meal preparation without a hair restraint; - The gas range with an oily grime build up and food debris around each burner; - One undated partially full 15 dozen case box with pasteurized shell eggs with one cracked egg inside the reach-in refrigerator; - An approximate 4 foot (ft.) x 6 in. section of unpainted ceiling and 18 in. of joint cement tape hung near the steam table area;- One rolling hall cart with four trays and uncovered individual pie desserts. During an interview on (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	08/28/25 at 2:15 P.M., the Dietary Manager (DM) said dated food labels were not on the large bins but should be, the bins shouldn't be used for multiple foods. There was a broken egg in the refrigerated case box, but it should have been thrown out. The plate warmer had sparked the last time it was plugged in and didn't work. It had not been used since, but it would be nice because some residents had complained about cold food in the past. There hadn't been cleaning logs kept for the dietary service staff. The ceiling and air conditioner vents, dishwasher, ice machine, and stove should be cleaned but wasn't. The Maintenance Director should have been told about the ceiling vents but wasn't. The ceiling over the steam table had been an issue and maintenance was aware of the 4 ft. section near the steam table. The repair service workers should not have made repairs during the food service, and they should have had hair restraints on while in the kitchen. During an interview on 08/29/25 at 1:28 P.M., Dietary Aide (DA) D said he/she did dishes mostly and didn't sign off on cleaning logs. Any workers or visitors to the kitchen should have a hair net. The Maintenance Director and DM should be told about kitchen equipment or building damage, the ceiling had been an issue for a while and maintenance was aware. During an interview on 08/29/25 at 1:35 P.M., DA E said he/she did the basics like reporting damage to the DM, the dishwasher and stove top should have already been wiped down, there was a big spill on the stove top yesterday and it needed deep cleaning. There should be cleaning logs. The ice machine was usually cleaned by the DM. Staff and visitors always need to use hair nets. Staff try to warn everyone in the kitchen to wear a hairnet, but it had been an issue this week. During an interview on 08/29/25 at 1:40 P.M., DA F said he/she normally cleaned daily but had not kept up with signing a cleaning log. No one should be allowed in the kitchen without wearing a hair net. During an interview on 08/29/25 at 1:48 P.M., the Administrator said the kitchen should be kept clean. The cleaning logs weren't kept up until recently. There should not be anyone in the kitchen without a hair net including outside repair service workers. There was a sign on the door to the kitchen and staff should remind any visitors to the kitchen to properly restrain their hair. The dishwasher and ice machine should not have a white build up. The dishwasher should be replaced, the ceiling, walls and vents should be kept in good repair throughout the kitchen. There was an issue with the air conditioning causing a leak. During an interview on 08/29/25 at 3:23 P.M., the Maintenance Director said he/she oversaw the repairs in the kitchen and the rest of the building. He/She was aware of the damaged ceiling in the kitchen. There was a leak from the air conditioner, and it had been fixed before and it caused the damage to the ceiling. He/She hadn't been asked to clean the vents in the kitchen.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 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 41.Review of the facility's policy titled, QAPI Policy, dated January 2024, showed:-The QAPI Program consists of monthly/quarterly meetings, daily quality assurance activities, QAPI tasks, and performance improvement plans;- Did not address the required members of the QAA Committee. Review of QAA Committee Minutes, dated 01/16/25, showed:- The Administrator, the Infection Preventionist, Human Resources, a Certified Nurse Assistant (CNA), and Registered Nurse (RN) attended the meeting;- No documentation the DON or the Medical Director attended the meeting. Review of QAA Committee Minutes, dated 08/06/25, showed: - The Administrator, Director of Nursing (DON), Social Services Designee (SSD), and Human Resources attended the meeting;- No documentation the Infection Preventionist and the Medical Director attended the meeting.During an interview on 08/29/25 at 1:16 P.M., the Administrator said they had not been consistent with the quarterly meetings. They had a meeting in June 2025, but she couldn't find the minutes. They didn't do one in July. The only other meeting they had was in January 2025. The QAA/QAPI meetings did not always have the required members but should include the Medical Director, Administrator, DON, Infection Preventionist, and two other staff members at least quarterly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 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 for one resident (Resident #14) out of two sampled residents and wound care for one sampled resident (Resident #33) out of one sampled resident. The failed to provide a safe and sanitary environment by failing to disinfect the multi-use glucometer (a device used to measure blood sugar) per the manufacturer's instructions for two residents (Residents #13 and #21) out of two sampled residents and when obtaining FSBS. The facility failed to correctly screen three residents (Residents #5, #31, and #33) for tuberculosis (TB - an infectious disease characterized by the growth of nodules in the tissues, especially the lungs) out of five sampled residents required by state regulation 19 CSR 20-20.100. The facility also failed to establish and maintain an infection prevention and control program (IPCP) that identified a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, and other individuals providing services. This had the potential to affect all residents in the facility. The facility's census was 41. Review of the facility procedure titled, Peri Care, undated, showed: - Wash hands, put on gloves, wash and dry upper thighs, wash peri area using a different part of the washcloth for each stroke, rinse area and dry, clean rectal area, rinse and dry area, remove gloves and wash hands. The facility did not provide a policy regarding infection control practices during wound care. Review of the facility's policy titled, Infection Prevention and Control Manual - Standard Precautions – Gloves, dated 2019, showed: - Disposable single-use examination gloves are worn when hand contact with blood, other potentially infectious material, mucous membranes and non-intact skin is anticipated, handling or touching contaminated items or surfaces, caring for a resident with uncontained body fluids or known or suspected drug-resistant organism colonization or infection. Review of the facility's policy titled Infection Prevention and Control Manual – TB Control Plan – Tuberculosis Screening - Residents, dated 2019, showed: - This facility has a comprehensive TB screening program that is administered by the Infection Control Nurse at the direction of the Quality Assurance Committee; - Tuberculin Skin Test (TST) for all new admissions, a TST will be done within 72 hours after admission if there is no documented TST from within three months before admission; - Some states may have different requirements for annual screening. Follow state and local guidelines; - TST results will be documented in the resident's medical record. Skin test results will be documented in millimeters (mm) of induration rather than stating results of positive or negative; - All reports or copies of the TST or Interferon-Gamma Release Assay (IGRA – a blood test to detect TB) and any chest x-rays and medical evaluation conducted should be maintained in the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident's medical record. Review of facility policy titled Infection Prevention and Control Manual, Cleaning and Disinfecting Glucose Meters, dated 2019, showed: - Apply gloves before performing a blood glucose test; - Dispose of used fingerstick devices and lancets in approved sharps container; - Remove gloves and perform hand hygiene; - Apply new gloves; - Thoroughly clean visible soil or organic material from glucometer before disinfection - Perform hand hygiene after removing gloves; - Follow manufacturer's guidelines for cleaning and disinfecting of glucose meters. Review of the Evencare G3 Meter manufacturer guidelines, dated 2017, showed: - The Evencare G3 Meter should be cleaned and disinfected between each patient. The meter is validated to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. The following products have been approved for cleaning and disinfecting the EVENCARE G3 Meter: Dispatch Hospital Cleaner Disinfectant Towels with Bleach; Medline Micro-Kill+™ Disinfecting, Deodorizing, Cleaning Wipes with Alcohol; Clorox Healthcare Bleach Germicidal and Disinfectant Wipes; Medline Micro-Kill™ Bleach Germicidal Bleach Wipes; - Clean the meter with a disinfecting wipe. Wipe all external areas of the meter including both front and back surfaces until visibly wet. Allow the surface of the meter to remain wet at room temperature for the contact time/kill time listed on the canister. Then, wipe meter dry or allow to air dry. Review of the directions for Micro-Kill One Germicidal Alcohol Wipes, showed: - To disinfect hard, non-porous surfaces, use one or more wipes, as necessary, to thoroughly wet the surface treated; - Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens; - Allow surface to air dry. Review of the facility's Infection Prevention and Control Program policy, revised on 08/2016 and unsigned, showed the policy did not include: - When and whom possible incidents of communicable disease or infection should be reported; - When and how isolation should be used for a resident and address resident room assignments; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food; - Environmental cleaning/disinfection of high-touch surfaces in common areas, resident rooms, and resident care equipment; - Maintain a system for recording incidents identified under the facility IPCP and the corrective actions taken by the facility; - Which communicable diseases will be reported to local/state public health authorities; - Education and competency assessment of the staff; - Education of the residents and their representative on the facility IPCP. 1. Review of TB testing for Resident #5 showed: - admission date of 06/26/25; - No documentation of a two-step TST upon admission. 2. Observation of Resident #13's blood glucose monitoring on 08/27/25 at 10:44 A.M., showed: - Certified Medication Technician (CMT) A performed blood glucose monitoring; - CMT A cleaned the glucometer for 15 seconds with a Wipes Plus Disinfecting Wipe; - CMT A placed the glucometer on top of the treatment cart; - CMT A failed to use an approved cleaning and disinfecting wipe per the glucometer's manufacturer guidelines. 3. Observation of Resident #14's peri care on 08/27/25 at 11:58 A.M., showed: - Certified Nurse Assistant (CNA) K put on a gown, performed hand hygiene, put on gloves, and entered the room; - CNA K picked up the trash can with his/her left hand and sat it down beside him/her on the floor; - The resident rolled to the left side and CNA K removed a bed pan filled with urine from under the resident with his/her right hand and sat it down on the floor; - CNA K did not change gloves and did not perform hand hygiene, and provided peri care to the resident with his/her left hand; - CNA K removed the gloves, did not perform hand hygiene, and put on new gloves; - CNA K fastened the brief and covered the resident with a blanket; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- CNA K picked up the bed pan filled with urine and emptied it into the resident's bathroom toilet; - CNA K removed gloves and performed hand hygiene. 4. Observation of Resident #21's blood glucose monitoring on 08/27/25 at 11:00 A.M., showed: - CMT A performed blood glucose monitoring; - CMT A cleaned the glucometer for 10 seconds with a Wipes Plus Disinfecting Wipe; - CMT A placed the glucometer on top of the treatment cart; - CMT A failed to use an approved cleaning and disinfecting wipe per the glucometer's manufacturer guidelines. 5. Review of Resident #31's medical record showed: - admission date of 05/12/21; - No documentation of previous TST testing or a sign and symptom assessment for 5/2024 – 5/2025. 6. Review of Resident #33's medical record showed: - admission date of 02/09/25; - A first step TST administered on 02/10/25, with no result or read date; - No second step TST. 7. Observation of Resident #33's wound care on 08/27/2025 at 11:07 A.M., showed: - Registered Nurse (RN) B performed hand hygiene, prepared needed items on the treatment cart, cleaned the scissors with Micro Kill One Germicidal Alcohol wipe, put on gloves and gown, entered the room, opened and placed a barrier drape on the foot of the residents' bed, a sat the supplies on the barrier drape; - RN B assisted the resident to lower his/her pants and brief and rolled to the left side with no dressing in place to the coccyx (small triangular bone at the base of the spine); - RN B removed the gauze saturated with wound cleanser from a plastic cup, cleaned the open area to the coccyx, and removed a brown substance from the wound; - RN B did not change gloves, did not perform hand hygiene, removed dry gauze from a second plastic cup, and dried the wound area; - RN B did not change gloves, did not perform hand hygiene, removed calcium alginate (a highly absorbent wound dressing) from the package, used scissors to cut a small wound size piece, placed it in the wound bed, did not change gloves, did not perform hand hygiene, opened a bordered dressing, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	removed a marker from his/her pant pocket, wrote on the dressing, returned the marker to his/her pant pocked, and applied the bordered dressing to the coccyx wound; - RN B did not change gloves, did not perform hand hygiene, removed the gauze saturated with wound cleanser from the plastic cup, wiped the right groin area two times with the same the gauze, discarded the gauze, removed another gauze saturated with wound cleanser from the cup, and wiped the left groin two times with the same gauze; - RN B did not change gloves, did not perform hand hygiene, removed a clean dry gauze from a second cup, dried both sides of the groin, picked up a bottle of Nystatin powder (an antifungal medication) and applied to both sides of the groin, and sat the bottle on the bedside table without a barrier; - RN B did not change gloves, did not perform hand hygiene, assisted the resident to pull up the brief and his/her pants into place, changed gloves and performed hand hygiene. 8. Review of the facility's IPCP binder showed: - No documentation of an IPCP program. During an interview on 08/28/25 at 9:20 A.M., the Administrator said the IPCP binder was brought to the daily meetings. The Director of Nursing (DON) brought the binder to the meetings, and they went over who was on antibiotics and why during the meetings. The infection control policies were reviewed monthly. During an interview on 08/28/25 at 9:24 A.M., the DON said there was a binder that had infection control policies and such in it. The policies had been reviewed but not sure when. During an interview on 08/28/25 at 12:20 P.M., the DON said the Administrator reminded her that the previous company took all the binders, including the infection control. The current company had all their policies online and they could pull them when needed. During an interview on 08/29/25 at 10:20 A.M., RN L said staff should perform hand hygiene upon entering a resident's room, put gloves on, remove anything dirty, perform hand hygiene, glove change, clean the resident up, hand hygiene, and glove changes again. A bed pan shouldn't be put on the floor. RN L said when sanitizing the glucometer in between residents, the wipes from the pink top disinfectant wipe container should be used. The glucometer was wiped and then left to air dry. During an interview on 08/29/25 at 10:26 A.M., the DON said with wound care and incontinent care, hand hygiene should be done upon entering the room, gloves put on, anything dirty removed, hand hygiene and glove changed, cleanse wound or clean the resident, and finish with hand hygiene and glove changed. A bed pan shouldn't be put on the floor. Disinfecting wipes should be used on the glucometer between residents and then left to air dry for three minutes. TB orders were entered upon admission with the first step administered on the day of admission, read 48 hours later, seven days later the second step was administered and read again 48 hours later. She administered a TST to all residents in January as part of an annual, not knowing that sign and symptoms could be done. But either a TST or sign and symptoms should be done annually. During an interview on 08/29/25 at 10:40 A.M., CNA I said hand hygiene should be done when entering the room, between dirty and clean care, and at the end of care. Also, glove changes should happen (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	between dirty and clean care. A bed pan shouldn't be put on the floor. During an interview on 08/29/25 at 10:42 A.M., CNA J said hand hygiene should be done at the beginning with gloves on, dirty gloves changed, care performed, gloves removed, hand hygiene performed. A bed pan shouldn't be put on the floor. During an interview on 08/29/25 at 11:30 A.M., the Administrator said she would expect staff to follow the facility's policies and procedures regarding infection control, hand hygiene, and glove changes. Hand hygiene should be completed before going in and out of rooms and gloves changed between dirty and clean care. Residents should get a two-step TB on admission and then sign and symptoms annually. Glucometer cleaning should be done by using the Micro-Kill One Germicidal Alcohol Wipes from the purple top container. Antibiotics should be tracked per the guidelines.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to maintain an Infection Prevention and Control Program (IPCP) that included an antibiotic stewardship program to include an infection surveillance and antibiotic use protocols. This deficient practice had the potential to affect all residents in the facility. The facility census was 41.Review of the facility's policy titled, Infection Prevention and Control Manual Antibiotic Stewardship and Multidrug Resistant Organisms (MDROs) - Antibiotic Stewardship, dated 2019, showed:- Stewardship involves identifying the microbe (microorganisms) responsible for disease, utilizing evidence-based definitions when indicated; selecting the appropriate antibiotic along with documentation indicating the rationale for use, appropriate dosing, route, and duration of antibiotic therapy; and to ensure discontinuation of antibiotics when they are no longer needed;- Policy and procedural updates have been completed. Ongoing review and updates will be completed based on standards of practice, collaboration with the Medical Director and Pharmacy Consultant. Staff education will be provided to promote understanding and successful implementation with all policies, procedures and updates to the Antibiotic Stewardship Program;- Tracking and reporting of antibiotic use and outcomes will be completed in the facility to identify adherence to facility policy and procedures, use and outcomes. Tracking will allow the facility to identify patterns, prevalence of antibiotic use as well as specific ordering data. Outcomes (i.e. adverse drug events, antibiotic resistant organisms, C. difficile infections, etc.) will be tracked by the Infection Preventionist (IP) and discussed with the Quality Assurance (QA) Committee for action planning.Review of the facility's policy titled, Infection Prevention and Control Program Manual Surveillance - Infection Surveillance - Overview, dated 2019, showed:- Infection prevention begins with routine and ongoing surveillance to identify possible communicable diseases or infections before they can spread to other persons in the facility or have the potential to cause, an outbreak;- The facility closely monitors all residents who exhibit signs/symptoms of infection through ongoing surveillance and has a systematic method for collecting, consolidating, analyzing, and interpretation of data concerning the frequency and cause of a given disease or event, followed by dissemination of that information to those who can improve the outcomes;- The unit charge nurses will identify residents with symptoms or identified infections and complete the Criteria for Infection Report Forms for the respective type of infection;- The IP will ensure data collection to complete a comprehensive Monthly Infection Control Log for surveillance activities on the infection site, pathogen, signs and symptoms, resident location, summary and analysis of number of residents with infections;- The IP or designee will be alerted to identify any necessary interventions in order to identify trends or clusters for action;- The IP will keep an updated map of infections to identify any clusters or trends;- Data obtained from Process Surveillance Audits will be collected to analyze the compliance of staff with facility policies and procedures. Review of the facility's Antibiotic Stewardship Program Binder showed:- No documentation for August - December 2024 and February - August 2025;- Incomplete documentation related to appropriate indication of antibiotic use for January 2025 Infection/Antibiotic Log;- No documentation of any maps of infection to identify any clusters or trends.- The facility failed to document the prescribed antibiotic, the appropriate dosing, the route, and the duration of the antibiotic therapy, and did not include lab reports/findings.Review of the facility Matrix (a listing of all facility residents), dated 08/26/25, showed:- Seven residents currently received antibiotics.During an interview on 08/28/25 at 8:53 A.M., the Director of nursing (DON) said the previous Minimum Data Set (MDS - part of a federally mandated process for clinical assessment of all residents in certified nursing homes) Coordinator, who left in May 2025, had been the IP and was responsible for completing the antibiotic stewardship and surveillance logs. The antibiotic stewardship had not been updated since. She was not aware of the antibiotic surveillance log binder and just printed a list of the residents on antibiotics for the weekly meeting to discuss which residents were on antibiotics. She did not have a surveillance log where trending was tracked or mapped, and when labs were (continued on next page)

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	265504	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Current River Nursing Center, Inc	1015 North Grand Avenue Doniphan, MO 63935

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	completed, they were printed and placed in the lab binder until placed in the resident's chart. The resident's signs and symptoms should be documented in their chart in the nurse's notes. The DON said the IP had always been the MDS Coordinator since she took the DON position in October 2024. Registered Nurse (RN) M took over the MDS Coordinator and IP position May 2025, but he/she was not certified as an IP. During an interview on 08/28/25 at 9:21 A.M., the Administrator said the staff go over the DON's list of which residents were on antibiotics in their morning meeting every day. The antibiotic stewardship and surveillance binder had not been maintained since the previous MDS Coordinator/IP left in May 2025. She did not know it was not completed before or after the previous MDS Coordinator/IP left. She said the DON was responsible for the IP responsibilities after the previous IP left, even though she was not certified as an IP.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure at least one person with specialized training in infection prevention and control for the Infection Preventionist (IP - a professional who assures healthcare workers and residents are doing everything possible to prevent infection) was responsible for the duties of the position. This had the potential to affect all residents in the facility. The facility census was 41. Review of the facility's policy titled, Infection Prevention and Control Program, dated 2019, showed:-The facility will designate one or more individual(s) as the infection preventionist(s) who is responsible for the facility's Infection Prevention and Control Program (IPCP); -The IP will have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field; Is qualified by education, training, experience or certification; Works at least part-time at the facility; and has completed specialized training in infection prevention and control; Be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis; Be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.Review of the facility's policy titled, Infection Prevention and Control Manual - Antibiotic Stewardship & multi-drug resistant organisms (MDROs) - Antibiotic Stewardship, dated 2019, showed:- IP: The IP will be responsible for surveillance, infection definition based on standards of practice, education, tracking, data management, analysis of data, communication with the Director of Nursing (DON), Medical Director, and Consultant Pharmacist and ongoing system review.The facility did not provide documentation for any staff members who had completed the specialized training for the IP position. During an interview on 08/29/25 at 8:50 A.M., Registered Nurse (RN) M said he/she just started the IP role this week and had not started the required training. During an interview on 08/29/25 at 1:39 P.M., the DON said the facility did not have an IP at this time due to the previous IP left in May 2025. RN M just took over the IP position. RN M and herself would be working on getting his/her certification. She would expect the facility to have an IP with the appropriate qualifications and certifications, and no one followed up to make sure the training was completed. During an interview on 08/29/25 at 1:49 P.M., the Administrator said she would expect the facility to have an IP with the appropriate qualifications and certifications. The previous IP left in May 2025, and hadn't had an IP since. RN M would be completing the training for the IP, and they had another nurse who just started the IP training today. The DON was responsible for the IP duties but was not certified.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility's census was 41.Review of the facility's policy titled, Infection Prevention and Control Manual, dated 2019, showed: - Environmental Services will develop protocols, including schedules for cleaning and decontamination of the work site;- Environmental Services personnel are responsible for routine cleaning of resident rooms, floors, surfaces, emptying and inspecting waste containers, and routine cleaning of resident areas.Review of the facility's 400 Hall deep cleaning schedule, dated August 2025, showed:- room [ROOM NUMBER] scheduled on 08/25/25, 8/27/25, and 8/29/25. Review of the facility's Maintenance Repair Log, dated 04/11/25 - 08/27/25, showed:- No repairs needed to Rooms 106, 107, 301, 516, 500 Hallway shower and 500 dining room baseboards. 1. Observations on 08/26/25 at 10:35 A.M., and 12:15 P.M., and 8/29/25 at 1:15 P.M., of the 500 Hallway showed:- room [ROOM NUMBER] with no vinyl cove baseboard on the four walls;- Dining room missing a 6-foot (ft.) section of vinyl cove baseboard near the refrigerator;- Cracked and peeled shower wall caulk on the chrome shower faucet cover plate and with no shower handle; - Shower ramp missing two 2 inch (in.) x 2 in. ceramic tiles along the edge.2. Observation on 08/26/25 at 10:40 A.M., of the 100 Hallway showed:- room [ROOM NUMBER] with a 3 ft. x 2 ft. hole in the drywall with exposed insulation and multiple 2 in. diameter (dia.) dents in the wall section near the headboard beside the window;- room [ROOM NUMBER] with a 3-ft. section of vinyl baseboard behind the bathroom door with a brown substance. 3. Observations of room [ROOM NUMBER] and the 400 Hallway showed: - On 08/26/25 at 11:17 A.M., a strong urine odor and two emptied plastic urinals hung from the headboard while the resident lay in bed with no blanket. The hallway with a strong urine odor; - On 08/26/25 at 3:20 P.M., a strong urine odor and two urinals hung from the headboard with one emptied and one half filled with urine while the resident lay in bed. The hallway with a strong urine odor; - On 08/28/25 at 8:40 A.M., a strong urine odor, one urinal half filled with urine lay on the nightstand near the headboard, and the bed with an approximate 3 ft. dia. yellow stain on the wadded sheets near the center of the mattress. The hallway with a strong urine odor;- On 08/28/25 at 9:30 A.M., and 12:47 P.M., a strong urine odor, one urinal half filled with urine lay on the nightstand near the headboard, the bed had an approximate 3 ft. dia. yellow stain on the wadded sheets near the center of the mattress, and debris scattered over the majority of the floor space. The hallway with a strong urine odor;- On 08/28/25 at 3:15 P.M., a strong urine odor, one urinal half filled with urine lay on the nightstand near the headboard, the bed with an approximate 3 ft. dia. yellow stain on the wadded sheets near the center of the mattress, and debris scattered over most of the floor space while the resident lay in bed. The hallway with a strong urine odor. During an interview on 08/28/25 at 3:17 P.M., the resident in room [ROOM NUMBER] said he/she had been waiting for his/her urinal to be emptied by staff. He/She accidently spilled the urine on the floor and the bed today and he/she told staff the bed and sheets were damp. During an interview on 08/28/25 at 3:45 P.M., Registered Nurse (RN) M said room [ROOM NUMBER] should not smell like urine, but the resident was known to urinate in the floor which caused the odor. room [ROOM NUMBER] should not have been left in that condition all day, but the bed and sheets were wet from urine. The resident and the room should be checked at least every two hours.During an interview on 08/28/25 at 4:00 P.M., RN B said he/she would expect any resident's room to be kept sanitary and not have an odor. The resident in room [ROOM NUMBER] should not have been left with a wet bed. The resident was known to miss while using his/her urinal which could cause an odor. The room should be checked every two hours. 4. Observation on 08/29/25 at 12:50 P.M., of room [ROOM NUMBER] showed:- Four 2 in. x 6 in. dark wall paint brush marks on the white ceiling above the four dark painted walls; - Four 1/4 in. dia. holes along the left edge of the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heating ventilation and air conditioning (HVAC) unit and a light brown build up inside the ventilation louvers;- The bathroom with a non-intact caulk bead with a brown substance near the base of the toilet. During an interview on 08/29/25 at 1:00 P.M., the resident in room [ROOM NUMBER] said he/she was frustrated about the dark paint marks on the ceiling because it should be white. There were holes to the outside around the HVAC unit and the dusty vents need to be cleaned. The toilet had a dark ring around the base and floor that should be clean. He/She was not used to living like this. During an interview on 08/29/25 at 9:41 A.M., Housekeeper N said resident rooms should be checked twice per day throughout the day and at the end of the day he/she went back to check for spills. If there was a urine odor in a room, the floor was sprayed with bleach to clean it. If there was urine on the sheets, he/she told a Certified Nurse Assistant (CNA). If the mattress had a urine spill, he/she was supposed to wipe it down. There was one resident that had a problem with urine and his/her bed was normally sprayed every day on the 200 Hall. On the 400 Hall, there was a resident room issue for when the resident was out of bed, the housekeeping staff were supposed to bleach the mattress down and clean it every day. He/She didn't remember checking on room [ROOM NUMBER] this week. A CNA or nurse was told if he/she saw a urinal that needed to be emptied. If the floor had food or other debris on it, it was supposed to be cleaned up and the meal trays should be removed after a meal. During an interview on 08/29/25 at 10:08 A.M., Housekeeper O said he/she worked on the 400 Hall mostly but sometimes worked the 100 and 200 Halls together. There was often a urine odor from certain rooms but there hadn't been a lot of strong urine odors. Normally rooms were checked daily for the floors or big messes. If there was a urine odor from a bed, a CNA was told, but when a deep clean was needed, the mattress and frames should be cleaned. He/She had two rooms on the 400 Hall that should have been deep cleaned this week. One was room [ROOM NUMBER], and it should be done daily. room [ROOM NUMBER] was deep cleaned last Friday and once today. The housekeeping cart had a schedule for cleaning. The floors should also be checked, housekeeping shouldn't touch the urinals. The Housekeeping Supervisor was notified if there was damage to a room and he/she reported it to maintenance about damage to the rooms. During an interview on 08/29/25 at 1:48 P.M., the Administrator said there should be no urine odors but there were some rooms that were harder to keep up with on cleaning and deep cleaning. She expected extra deep cleaning and extra shower days for some residents. There should be checks at least every two hours for wet mattresses and extreme odors. room [ROOM NUMBER] should have been cleaned when the residents were out of the room. The rooms that had been painted should not have wall paint marks on the ceiling. The toilets should have a clean intact caulk bead, and no brown build up. The shower room faucets should have a handle. The shower floor ramp should not be missing ceramic tiles. The staff should be reporting concerns with the facility in the maintenance log, but she hasn't heard about any of problems with the 500 Hallway shower. During an interview on 08/29/25 at 2:17 P.M., the Maintenance Director said there should be cove base in the dining areas and in resident rooms where they were missing. The handle was missing from the unit shower faucet. All the floor tiles should be in place on the shower ramp. If the resident room walls were painted, the ceiling should remain white. There should not be dark paint marks on the white ceiling. The toilet and shower caulk seals should be clean and intact. He/She was not aware of all the issues, and they were not documented on the maintenance log.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review, the facility failed to identify, assess, and provide supportive interventions for one resident (Resident #6) out of one sampled resident with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event). The facility's census was 41. The facility failed to provide a policy regarding PTSD. 1. Review of Resident #6's medical record showed: - admission date of 04/12/24;- Diagnoses of PTSD, anxiety (persistent worry and fear about everyday situations), major depressive disorder (long-term loss of pleasure or interest in life) and dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning);- Severe cognitive impairment;- No trauma informed care assessment. Review of the resident's August 2025 Physician Order Sheet (POS) showed:- An order for prazosin (a blood pressure medication also used to treat nightmares associated with PTSD) 1 milligram (mg) by mouth at bedtime related to PTSD, dated 07/15/25;- An order for donepezil (a medication used to treat the symptoms of dementia) 10 mg by mouth at bedtime related to dementia unspecified severity without behavioral disturbance, psychotic disturbance (a mental disorder characterized by a disconnection from reality), mood disturbance (a mental health condition characterized by persistent and extreme changes in a person's emotional state), and anxiety, dated 07/15/25;- An order for trazodone (an antidepressant medication) 100 mg by mouth at bedtime related to major depressive disorder (Persistently low or depressed mood), dated 02/10/25;- An order for sertraline (an antidepressant medication) 100 mg 1.5 tablets by mouth one time a day for depression, dated 07/15/25;- An order for alprazolam (an antianxiety medication) 0.5 mg by mouth every morning and at bedtime for anxiety, dated 07/15/25;- An order for memantine (a medication used to slow the progression of dementia) 10 mg one tablet by mouth every morning and at bedtime for dementia, dated 07/15/25. Review of the resident's Care Plan, dated 04/12/25, showed:- Takes a psychotropic (medications that affect mental function, behavior, and experience) medication related to PTSD;- Did not address triggers that could cause resident trauma;- Did not address the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 08/29/25 at 10:26 A.M., the Director of Nursing (DON) said the facility had one resident with PTSD. The care plan should include monitoring, assessments of the medications, behaviors, depression, and safety for PTSD. It really depended on what the cause of the PTSD was. The cause of the PTSD should be part of the care plan. Triggers should also be listed. She didn't know what triggers the resident had. When the resident was admitted , the Social Services Designee (SSD) and nursing did the assessments. SSD dealt with more with the history of the resident. The Minimum Data Set (MDS - a federally mandated assessment to be completed by the facility) Coordinator was responsible for the care plan to ensure it had everything. During an interview on 08/29/25 at 11:30 A.M., the Administrator said PTSD should be care planned and include triggers and interventions. The PTSD assessments should be done. The MDS Coordinator or a nurse could do the assessments. The MDS Coordinator was responsible for ensuring the assessments were completed. During an interview on 08/29/25 at 11:40 A.M., the MDS Coordinator said he/she took the position in the middle of May this year. The PTSD assessments should be done but wasn't sure who was responsible for completing them. It wasn't an assessment on his/her list of responsibilities. He/She was responsible for ensuring the care plan addressed PTSD and it should include triggers, interventions, and preventions. Resident #6's assessment and care plan didn't address his/her PTSD.