STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265516	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Georgian Gardens Center for Rehab and Healthcare	1 Georgian Gardens Drive Potosi, MO 63664

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31057 Based on observation, record review and interview, the facility failed to provide care in a sterile manner for one resident (Resident #4) of 11 sampled residents and did not assess or notify the physician when the peripherally inserted central catheter (PICC), (a long, flexible tube that is inserted into a vein in the arm and threaded into a large vein near the heart, used to deliver fluids, blood transfusions, medications, and nutrition intravenously, and to draw blood samples) line was cut during a dressing treatment and subsequently removed without a physician's order, placing the resident at risk for possible complication of a catheter-related bloodstream infection (CRBSI), which can occur when bacteria enter the bloodstream through the catheter site due to improper sterile technique, potentially leading to serious systemic infection. The facility census was 88. The Administrator was notified on 12/17/24 at 4:50 P.M. of an Immediate Jeopardy (IJ) which began on 12/17/24. The IJ was removed on 12/17/24 as confirmed by surveyor onsite verification. Record review of the facility policy dated August 2014 Guidelines for Preventing Intravenous Catheter Related Infections, directed staff to: - Use either sterile gauze or sterile transparent, semi-permeable membrane to cover central or peripheral (a device used to draw blood and give treatments, including intravenous fluids (IV), drugs, or blood transfusions. A thin, flexible tube is inserted into a vein, usually in the back of the hand, the lower part of the arm, or the foot) catheter sites; - Removal of a midline or any central line is to be performed upon the order of a Physician or authorized prescriber in accordance with State Nurse Practice Act. Review of the following sources, Infusion Nursing: An Evidence-Based Approach, Third Edition edited by [NAME], [NAME], [NAME], [NAME], and [NAME]. 3. INS (Infusion Nurses Society) Policies and Procedures for Infusion Nursing, 3rd Edition and the Infusion Nursing Standards of Practice - Revised 2016; Journal of Infusion Nursing, Supplement to January/February 2016, Volume 39, Number 1S, showed upon removal of an infusion apparatus, appropriate staff should: - Verify physician order; - Measure the catheter and inspect the tip; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Use caution in the removal of a midline/PICC catheter, including precautions and interventions to prevent air embolism (blockage in an artery) and increase the likelihood of clot formation. Petroleum-based ointment and a sterile dressing may be applied to the access site to seal the skin-to-vein tract and decrease the risk of air embolus; - Position the patient so that the IV insertion site is at or below the level of the heart to reduce the risk of air embolus; - Apply a tourniquet to the upper arm by the shoulder if the catheter breaks during removal and a suspected fragment remains in the patient; - Not occlude arterial flow; - Notify the physician immediately and access emergency response system, as appropriate; - Stay with the patient and continue to monitor; - Document procedure, including catheter length, outcome and patient's response on the Midline/PICC progress record or other form as applicable. Review of Resident #4's medical record showed: - Admission to facility on 03/09/22 with last re-admission to the facility on [DATE]; - Cognition intact, own responsible party; - Able to make needs known; - Diagnoses of chronic obstructive pulmonary disease (a common lung disease that causes breathing problems by restricting airflow), osteomyelitis right hip abscess (a painful bone infection that can occur when bacteria or other germs spread to the bone), schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and hypertensive heart disease with heart failure (a group of conditions that can occur when high blood pressure (hypertension) goes unmanaged); - No PICC catheter monitoring sheet. Review of the resident's care plan showed no mention of the placement or care of a PICC line. Record review of the December 2024 Physician Order Sheet (POS), showed: - An order dated 11/28/24 change PICC line dressing weekly on Fridays for infection control; - An order dated 11/28/24 flush PICC line with normal saline (a sterile solution of water and salt), Heparin (an anticoagulant (blood thinner) that stops your blood from forming blood clots or making them bigger) 5 milliliters (ml) every shift for line patency; - An order dated 11/28/24 monitor PICC line insertion for bleeding and or signs and symptoms of infection every shift; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- An order dated 11/28/24 Daptomycin (antibiotic) intravenous solution reconstituted, 800 milligrams (mg) intravenously one time a day for bone infection; - No orders to remove the PICC line. Review of the hospital discharge summary, dated 11/27/24 showed the PICC line was inserted on 10/31/24 with 55 centimeters (cm) of line inserted. Observation and interview on 12/17/2024 at 11:35 A.M., showed: - Resident #4 sat in his/her wheelchair in his/her room; - No PICC line and or dressing to the resident's upper left arm; - The resident said Registered Nurse (RN) A tried to change the dressing over the PICC line and accidentally removed the line from his/her arm. The RN pulled the entire thing out of his/her arm, then left. He/She had not seen the nurse since. During an interview on 12/17/24 at 11:40 A.M., RN A said: - Licensed Practical Nurse (LPN) B informed him/her of difficulty with Resident #4's PICC line infusing the IV antibiotic this A.M.; - He/she went to assess the situation and attempted to access the PICC line dressing to make an observation; - The PICC line was covered with a transparent dressing so viewing the PICC line was not difficult; - It appeared that maybe a sterile gauze lying under the line may have been causing problems with the infusion; - The dressing was taped around the site too much, making it difficult to access the site; - He/she used his/her un-sterile scissors from his/her pocket and cut through the dressing, cutting the PICC line as well; - He/she pulled the rest of the PICC line out at that time and applied pressure to the site; - He/She threw the entire PICC line and dressing away in the waste container; - He/She did not make measurements or an observation of the condition of the PICC line after it was pulled out; - He/She had not contacted the physician or the Director of Nursing (DON) regarding cutting the line or removing the entire device; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- He/She had not been back into Resident #4's room since the PICC line was removed. No assessment had been made of Resident #4 since the event occurred and RN A was unsure what signs and symptoms to observe for; - He/She did not know if the facility had a policy in place for care of PICC line; - He/She was aware all dressing changes and treatments to a PICC line needed to be completed with sterile technique; - He/She was aware scissors from his/her pocket were not sterile. During an interview on 12/17/24 at 11:50 A.M., LPN B said: - The resident's PICC line flushed (the process of cleaning and rinsing the tube with a solution to prevent clotting and keep it clear) easily prior to administering the IV (intravenous fluids) antibiotics during the morning administration; - The antibiotic was running slowly and he/she was only able to administer approximately half the dosage; - After removing the IV antibiotic, the PICC line flushed easily again; - He/She immediately reported the antibiotic infusion issue to RN A; - RN A and LPN B assessed the site on Resident #4, when RN A attempted to remove the transparent dressing covering the PICC line site; - RN A took scissors from his/her pocket and cut the dressing, also cutting through the PICC line tubing; - RN A then pulled the remaining line from the resident's arm and disposed of it in the trash container; - RN A said he/she would notify the physician; - He/She was unsure if the facility had a policy on the care of a PICC line; - Any access or dressing changes with PICC lines is a sterile procedure; - He/She was unsure if an RN can pull a PICC line without a physician order; - He/She said no one had been in to assess or monitor Resident #4 since the PICC line was removed. During an interview on 12/17/24 at 11:55 P.M., the Assistant Director of Nursing (ADON) said: - RN A had just made him/her aware of the PICC line being cut while attempting to access the site this morning; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Any treatments to a PICC line are to be sterile, RN A should not have used scissors from his/her pocket to cut the dressing. This is not a safe practice. RN A should have not have used scissors at all around a PICC line. That is not a safe practice; - RN A should have immediately notified the him/her, the DON and the physician of cutting the line, and certainly after removing the PICC line. RN A should have assessed and monitored the resident for any further changes in condition and document the incident in the medical record. Observations on 12/17/24 at 12:00 P.M., showed: - RN A brought a black trash bag containing the PICC line and dressing into the ADON's office; - The ADON laid the PICC line out on the desk and measured from the entry point of the line to the cut end showing a measurement of 13 centimeters (cm), the second part of the line measured 51. 5 cm; - PICC line insertion point was cut straight across with no jagged edges. During an interview on 12/17/24 at 12:17 P.M., RN A said he/she had not been in contact with the physician. No assessment of the resident had been performed. During an interview on 12/17/24 at 12:27 P.M., LPN B said he/she had not seen the resident or assessed his/her condition. During an interview on 12/17/24 at 2:00 P.M., the resident's physician said: - He/she was just informed by the DON of Resident #4's PICC line being cut and removed this morning; - The nurse should have notified him/her immediately of the removal due to the PICC line could have been torn or broken off, which places the resident in immediate danger of complications; - He/She has a nurse specifically assigned to the facility in the office to take calls from the facility and to reach him/her immediately. - The PICC line should have been inspected for any damages prior to being thrown away; - The resident should be assessed and sent to the emergency room for evaluation and possible replacement of the PICC line. During an interview on 12/17/24 at 1:25 P.M., the DON said she would have expected the RN and or LPN to notify the physician immediately after the PICC line had been cut and removed, assessments started, and observation for signs of bleeding, shortness of breath and vital signs taken and or call an ambulance. RN A should have known not to use any sharp object to access the PICC line or any other type of IV line. The DON is unsure if a facility policy is in place specifically related to PICC line care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/17/24 at 1:35 P.M., the Administrator said he is not a nurse, but would have expected the nurse to call the DON and or physician for further guidance immediately. MO245912 NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s).