STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265519	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Health Care Facility	119 West Forest Bolivar, MO 65613

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34906 Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection control program when the facility failed to implement an enhanced barrier precaution (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities) policy timely and when staff failed to follow infection control practices, per standard of practice, when proving would care to residents (Resident #1 and Resident #2) putting the wounds at risk for contamination. The facility census was 67. Review of the facility's policy titled, Enhanced Barrier Precautions for Long Term Care, IP02-08, effective 09/2024, showed the following: -It is the policy of the facility to implement EBP for the prevention of transmission of MDROs; -The purpose of the policy was to prevent the spread of MDROs and maintain a home like environment for residents; -EBP are an infection control intervention designed to reduce transmission of MDROs in nursing homes. EBP involve gown and glove use during high-contact resident care activities for resident known to be colonized with a MDRO, as well as those at increased risk of MDRO acquisition (e.g., residents with wound or indwelling medical devices); -High contact resident activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, or device care or use of central line, urinary catheter, feeding tube, tracheostomy/ventilator, or during wound care of any skin opening requiring a dressing; -A resident will be place on EBP with a wound even if the resident is not known to be infected or colonized with a MDRO. Review of the facility's policy titled, Hand Hygiene, IP02-07, revised July 2021, showed the following: -Hand hygiene is the single-most effective method of reducing the transmission of microorganisms in a healthcare setting. The term hand hygiene; (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 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

-Perform hand hygiene on ungloved hands with approved alcohol based hand rubs (ABHR) or soap and water;

-Five moments for hand hygiene from the World Health Organizations (WHO) are before touching a resident; before a clean or aseptic procedure; after body fluid exposure risk; after touching a resident; and after touching a resident's surroundings;

-Examples of opportunities for hand hygiene include use ABHR before crossing the threshold/entering a resident's room; before donning sterile or non-sterile gloves; before donning any personal protective equipment (PPE - gown, mask, gloves); before inserting or handling invasive devices; before moving from a contaminated body site to a different body site during the care of the same resident; after contact with the resident's skin, body fluids, excretions, mucous membranes, or dressings; after contact with objects in the immediate vicinity of residents; after doffing of sterile or non-sterile gloves; after doffing of any PPE, and upon crossing the threshold when exiting the patient's room.

-Use soap and water when hands are visibly soiled.

Review of the facility's policy titled, Cleaning and Disinfecting Patient Care Equipment, IP07-01, revised January 2020, showed the following:

-Purpose to provide guidelines for the recognition of clean or soiled equipment and guidelines for storage and treatment after use and to define and establish standards for assuring that non-critical items (as defined by the Centers for Disease Control (CDC)) as those that come in contact with intact skin but not mucous membranes and shared resident equipment is clean before use and that used or contaminated equipment is appropriately cleaned before reuse;

-Disinfection is a thermal or chemical destruction of pathogenic and other types of microorganisms. Disinfection is less than sterilization because it destroys most recognized pathogenic microorganisms, but not necessary all microbial forms like bacterial spores. This is most often completed by use of an approved hospital disinfectant or chemical sterilant;

-Resident care equipment for use for more than one resident will be disinfected with an organization approved disinfectant after each use;

-Follow manufacturer's instructions for cleaning, disinfecting, and maintaining medical equipment;

-Always allow for recommended contact time when using disinfectant wipes and solution.

1. Review of Resident #1's face sheet showed an admitted [DATE].

Review of the resident's diagnosis and problem list showed the resident's diagnoses included Guillain-Barre syndrome (a rapid onset muscle weakness caused by immune system damaging the peripheral nervous system) , paraplegia (chronic condition that affects the ability to move or feel the legs/feet), polyneuropathy (acute or chronic damage or disease affecting the peripheral nerves), major depressive disorder, and anxiety.

Review of the resident's care plan for pressure ulcers, dated 04/02/24, showed staff care planned perineal cares as needed and wound cares as ordered.

(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's quarterly Minimum Data Set (MDS - a federally-mandated comprehensive assessment tool completed by facility staff), dated 07/08/24, showed the following: -Presence of one stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) and one stage III (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) pressure ulcer; -Presence of moisture associated skin damage; -Pressure ulcer care. Review of the resident's medial sacral (a triangular bone located at the base of the spine) pressure ulcer assessment, dated 09/02/24, showed the following: -Present on admission; -Stage III; -Wound length = 11.0 centimeters (cm); -Wound width = 9.0 cm; -Wound depth = 2.0 cm; -Presence of pain = No; -Wound appearance = Eschar (dead or devitalized tissue that is hard or soft in texture), purple reddened, slough (non-viable yellow, tan, gray, green or brown tissue), tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound), unapproximated, undermining (the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface); -Wound surrounding tissue appearance: Bright red, pink; -Surrounding tissue temperature: Warm; -Wound drainage description: Creamy; -Wound drainage amount: Moderate; -Wound drainage odor: No odor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current medial sacral treatment orders, dated 09/04/24, showed the following: -For tunneling and undermining wet to dry packing with Vashe (a solution used to cleanse, moisten, and aide in debridement of wounds); apply nickel layer of Santyl (an enzymatic debriding agent - used to help remove dead tissue from a wound) to necrotic area; cover with normal saline moistened gauze; then cover with vaseline gauze, ABD (absorbent gauze pad) pad, and tape; -Change two times per day and as needed if soiled/displaced. Review of the resident's left lower buttock pressure ulcer assessment, dated 09/02/24, showed the following: -Stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer.); -Present on admission; -Wound length = 2.9 centimeters (cm); -Wound width = 1.7 cm; -Wound depth = 1.8 cm; -Presence of pain = No; -Wound appearance = Beefy red, bone visible, muscle visible, tunneling; -Wound tunneling position = 4 o'clock; -Wound tunneling depth = 3.5 cm -Wound surrounding tissue appearance: Dark red, pink, tunneling,weeping; -Surrounding tissue temperature: Warm; -Wound drainage description: Sanguineous (containing blood); -Wound drainage amount: Moderate; -Wound drainage odor: No odor. Review of the resident's current left lower buttock treatment orders, dated 09/04/24, showed the following: -Cleanse wound and surrounding area with wound cleaner, rinse with saline, pack wound with Vashe soaked Kerlix (rolled gauze), cover with ABD pad and secure with tape; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Change the dressing two times per day and as needed. Observation on 09/09/24, at 10:30 A.M., showed the following, -Licensed Practical Nurse (LPN) A and LPN B entered the resident's room to perform wound care to the resident's two pressure ulcers; -LPN A and LPN B washed their hands and donned gloves. Neither nurse donned isolation gowns; -LPN A removed pillows from behind the resident's back, buttocks, and legs, and pulled the resident's slacks and brief down, and assisted the resident to turn more to his/her right side, exposing the resident's buttocks; -The resident had a urinary catheter; -Two dressings were present to the resident's skin, one on the left lower buttock and one to the sacrum, both dated 09/08; -The resident had a small amount of feces present near his/her rectum; -LPN A placed his/her hand on the outside of the resident's soiled brief, and used the brief to remove the feces from the resident's rectum; -Without washing or sanitizing his/her hands or changing gloves, LPN A removed the soiled dressings from the resident's left lower buttocks and coccyx (tailbone) and placed the dressings on the brief; -LPN B sprayed wound cleanser onto the existing sacral wound packing located in the resident's sacral wound and LPN A removed the packing from the wound. The gauze packing was covered in tan colored drainage; -LPN A then placed the resident's soiled brief and dressings into the trash can. A small tear (approximately 1 cm in length) to the back of LPN A's glove over one of his/her fingers was visible; -LPN B dropped the bandage scissors onto the floor, picked the scissors up off the floor with gloved hands, took the scissors to the resident's sink, and washed off the scissors with soap and water; -Wearing the same gloves and without washing his/her hands, LPN B opened a package of rolled gauze and touched the gauze with the same gloves, as he/she cut strips of the gauze using the scissors; -LPN B handed LPN A the pieces of gauze, LPN A used the gauze and wound cleanser to clean the surfaces of the wound to the resident's left buttock and wearing the same gloves. The LPN used different pieces of gauze to cleanse the resident's sacral wound. LPN A then removed his/her gloves, sanitized his/her hands, and donned clean gloves; -LPN A then removed gloves and exited room to get more Vashe from the medication cart; -LPN A reentered the room and sanitized his/her hands and donned gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A placed Vashe moistened gauze into the left lower buttock wound using a swab to pack the gauze into the wound tunnel. LPN A then used the scissors to cut the gauze, placed the scissors on a draw sheet on the resident's bed, covered the wound with an ABD pad, and secured the dressing with tape ; -Without washing his/her hands or changing gloves, LPN A placed Santyl on the necrotic wound edges of the sacral wound using a sterile swab and then placed Vashe soaked, cut gauze into the sacral wound with gloved hands; -LPN B then picked up the scissors off the resident's bed and cut more rolled gauze, while LPN B held onto the gauze, LPN A then placed these pieces of gauze over the packed sacral wound; -Without washing hands or changing gloves, LPN B picked up and unfolded an ABD pad and handed it to LPN A. LPN A placed the ABD pad over the resident's sacral wound and secured with tape. 2. Review of Resident #2's face sheet showed an admitted [DATE]. Review of the resident's diagnoses list showed current diagnoses included neuromuscular scoliosis (sideways curvature of the spine), Arnold Chiari Syndrome (a condition present at birth in which the brain tissue extends into the spinal canal), and depression. Review of the resident's pressure ulcer care plan, dated 08/15/19, showed the following: -Due to the resident's curved and twisted spine and his/he paralysis of the left side. He/she used a wheelchair for mobility. This puts the resident at a higher risk for skin breakdown. He/she also leans to the left while sitting up in the wheelchair. He/she had developed a pressure ulcer to the left lower back that is being monitored by the wound clinic; -Monitor skin for redness or breakdown and notify the nurse; -Dressing change and treatment to pressure ulcer as ordered. Review of the resident's current left lateral back pressure ulcer treatment orders, dated 08/01/24, showed the following: -Cleanse wound with wound cleanser, apply nickel-sized layer of Santyl to the wound for enzymatic debridement, pack moistened 4 x 4 gauze into the wound, apply ABD pad, and secure with tape, Review of the resident's quarterly MDS, dated [DATE], showed the following: -Presence of one stage III pressure ulcer; -Pressure ulcer care; -Application of ointments/medicine/dressings to skin (other than to feet). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's left lateral back pressure ulcer assessment, dated 09/02/24, showed the following: -Stage IV; -Acquired in facility; -Wound length = 4.9 centimeters (cm); -Wound width = 2.0 cm; -Wound depth = 1.8 cm; -Presence of pain = No; -Wound appearance = Beefy red, bleeding, granulation, pink, slough, undermining; -Wound surrounding tissue appearance: Pink, purple; -Surrounding tissue temperature: Warm; -Wound drainage description: Tan; -Wound drainage amount: Moderate; -Wound drainage odor: No odor; -Comments: Resident seen by wound clinic on 08/01/24 and orders changed. Wound bed looks clean with minimal discomfort noted with dressing changes. Observations on 09/09/24, at 1:19 P.M., showed the following: -LPN B entered the resident's room to perform wound care; -The resident sat in his/her wheelchair; -The nurse did not don an isolation gown; -The nurse placed additional gloves on the resident's over bed table without cleaning the table. The resident's over bed table had smears and a white substance on the surface; -With clean gloves, the nurse removed the resident's soiled back dressing, dated 09/05. The wound did not contain any packing; -The wound dressing contained a moderate amount of tan and green drainage and had an odor; -Wearing the same gloves, the nurse cleansed the wound with gauze and wound cleanser; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nurse removed gloves and stepped out of the resident's room to obtain more supplies; -While the nurse was out of the room, the resident rested back against his/her wheelchair back and the open wound rested against the vinyl wheelchair back; -The nurse returned and the resident leaned forward. The nurse sanitized his/her hands and picked up a pair gloves off the over bed table. The nurse donned the glove and, using a swab, applied Santyl to the wound; -The nurse then placed gauze into the wound using gloved hands and covered the wound with an ABD pad and tape to secure in place. 3. During an interview on 09/10/24, at 12:04 P.M., LPN A said the following: -Prior to resident wound care, staff should set up a clean field and place items for use on a clean surface; -The nurse would wash his/her hands and don gloves prior to removing soiled dressings; -The nurse should then remove gloves and wash or sanitize hands and don new gloves before cleaning the wound; -The nurse should then remove the gloves and wash or sanitize his/her hands and don new gloves prior to applying clean packing/dressings; -The nurse should then remove his/her gloves and wash his/her hands after completion of the wound treatment; -The nurse should treat each wound separately; -He/she did not recall have a tear in his/her gloves; -The nurse should have sanitized the scissors with a bleach wipe, washed his/her hands and changed gloves; -He/she thought Resident #1's dressings were stuck together with tape and that is why both dressings came off together; -Normally, he/she would treat each wound separately; -If a nurse had to step out of a room in the middle of wound care, the nurse should first place dry gauze over the would to decrease the risk of possible contamination. 4. During an interview on 09/09/24, at 1:45 P.M., LPN B said the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-During wound care staff should wash hands and don gloves to remove existing dressings, then wash or sanitize hands and change gloves prior to cleansing the wound, then wash or sanitize hands and change gloves prior to placement of the clean dressing, then remove gloves and wash hands prior to exiting room; -He/she should set up a clean field for the dressing supplies and gloves. 5. During an interview on 09/10/24 at 11:33 A.M., LPN C said the following: -On Friday, 09/06/24, during the staff meeting, facility management said staff would start using EBP during wound care and any invasive procedures, and EBP would include gowns and gloves; -EBP is a new thing to the facility; -Prior to resident wound care, staff should set up a clean field and place items for use on a clean surface; -The nurse would wash his/her hands and don gloves prior to removing soiled dressings; -The nurse should then remove gloves and wash or sanitize hands and don new gloves before cleaning the wound; -The nurse should then remove the gloves and wash or sanitize his/her hands and don new gloves prior to applying clean packing/dressings; -The nurse should then remove his/her gloves and wash his/her hands after completion of the wound treatment; -The nurse should treat each wound separately. 6. During interviews on 09/09/24, at 2:00 P.M. and 2:10 P.M., the Director of Nursing (DON) said the following: -The facility had not put in place policies for staff to utilize EBP; -When the facility begins using EBP, staff will use gown and gloves during wound care; -Nurses should wash or sanitize hands and don gloves prior to removing soiled wound dressings; -After removal of soiled dressings, nurses should remove gloves and again wash or sanitize hands; -Nurse should then don a new pair of gloves and clean the wound; -After cleaning of the wound the nurse should remove gloves and wash or sanitize hands; -Nurse should don a new pair of gloves prior to dressing the wound; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Nurse should sanitize equipment, such as bandage scissors, with Sani-cloths (bleach wipes) per the manufacturer's recommendations; -Staff should not place scissors on the resident's bed, and if dropped in the floor, staff should re-sanitize the scissors and remove gloves and wash or sanitize hands; -Staff should place supplies on a clean surface in the resident's room; -If treating multiple wounds, staff should treat each wound separately without cross-contamination. 7. During an interview on 09/09/24, at 2:00 P.M., the Director of Long-Term Care Nursing Operations said the following: -The corporation is in the process of working on their EBP policies; -The policy was near completion and the corporation was also working on an online inservice for EBP; -On Friday, 09/06/24, the facility started talking to staff about EBP; -He/she was aware EBP protocols should already be in place within the facility, but was a work in progress; -Staff should use gloves and gown during wound care and face protection if irrigating wound or risk of splash; -Facility staff have not started using EBP During an interview eon 09/10/24, at 3:11 P.M., the Administrator said the following: -The corporation was working on a policy for EBP; -The facility talked about what would be implemented regarding the use of EBP at the staff meeting on 09/06/24; -Nurses should use basic hand hygiene during wound care; -Expect nurses to wash or sanitize hands and change gloves before, between, and after any procedure; -Nurses should appropriately clean any equipment used as well. MO00241562