STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265536	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health & Rehabilitation	1600 East Rollins St Moberly, MO 65270

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 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide care and assistance to perform activities of daily living for any resident who is unable.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 35615

Based on observation, interview, and record review, the facility failed to ensure two residents (Resident #2 and #7) in a review of seven sampled residents, who the facility identified as dependent on staff for Activities of Daily Living (ADLs), received treatment and care in accordance with professional standards of practice to meet the resident's physical, mental and psychosocial needs. Staff failed to ensure Resident #2 was kept clean and dry, repositioned in bed, provided access to a call light, and had access to water and fluids. Staff also failed to provide incontinence care to Resident #7 for over seven hours when the resident had informed staff. Instead of providing care, staff covered the resident's soiled bed linens with a towel. The facility census was 84.

Review of the facility policy, Activities of Daily Living (ADL), Supporting, dated March 2018, showed the following:

-Residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living;

-Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming and personal hygiene;

-Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care), mobility, (transfer and ambulation), elimination (toileting), dining (meals and snacks) and communication;

-Care and services to prevent and /or minimize functional decline would include appropriate pain management, as well as treatment for depression;

-A resident's ability to perform ADLs would be measured using clinical tools, including the Minimum Data Set (MDS, a federally mandated assessment instrument, completed by facility staff). Extensive assistance, the resident performed part of the activity, staff provided weight-bearing support. Total dependence, full staff performance of an activity with no participation by the resident for any aspect of the ADL activity.

1. Review of Resident #2's care plan, dated 6/26/24, showed the following:

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health & Rehabilitation	1600 East Rollins St Moberly, MO 65270

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of stroke with paralysis of the right side, aphasia (difficulty communicating due to damage to the parts of the brain that control language), apraxia (difficulty with skilled movement caused by brain disease or damage), restlessness and agitation, generalized arthritis, muscle weakness, palliative care (end of life care); -The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to immobility, physical limitation. Staff should converse with the resident while providing care, encourage family involvement; -The resident had an ADL self-care deficit related to a stroke. Staff should provide bed rails (metal bars attached to the bed) to aid in bed mobility, avoid scrubbing and pat sensitive skin dry, check nail length and trim as necessary. The resident was dependent on staff for bathing, bed mobility, dressing, toileting, transfers, eating, and personal hygiene. Staff should allow sufficient time for dressing and undressing and provide simple comfortable clothing. Staff should encourage the resident to use the call light for assistance; -The resident had limited physical mobility. Staff should provide gentle range of motion as tolerated with daily care; -The resident had communication problems related to aphasia and stroke. Staff should anticipate and meet the resident's needs, allow adequate time for the resident to respond. Ensure and provide a safe environment with the call light in reach; -The resident had right sided paralysis and weakness related to stroke. Staff should provide range of motion with morning and evening care daily, reposition the resident as tolerated and at least every two hours; -The resident had potential and actual impairment to skin integrity. Staff should avoid the resident scratching and keep hands and body parts from excessive moisture. Keep the resident's fingernails short. Prevent skin injury, encourage good nutrition and hydration to promote healthier skin, use a draw sheet or lifting device to move the resident and use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface; -The resident received hospice (end of life) services. Staff should establish routine with facility and hospice care, collaborate with the plan of care. Provide maximum comfort for the resident. Review of the resident's Significant Change Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 7/18/24, showed the following: -Severely impaired cognition; -Functional limitation in range of motion, impairment on one side to upper and lower extremity; -Dependent on staff for eating, oral hygiene, toileting, bathing, dressing, personal hygiene and transfers; -Required substantial or maximal staff assistance with bed mobility; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Valley View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 East Rollins St Moberly, MO 65270	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required an indwelling urinary catheter (a sterile tube inserted into the bladder used to drain the bladder of urine); -Always incontinent of bowel; -Resident had Moisture Associated Skin Damage (MASD, incontinence associated dermatitis, perspiration, drainage caused from wet or soiled skin); -Skin treatments included a turning and positioning program and application of ointments and medications; -Received hospice care. Observation on 7/25/24 from 9:45 A.M. to 10:15 A.M. showed the following: -The resident lay in bed wearing a facility gown pulled down to his/her mid chest. The resident's right arm was flaccid (unable to move) and dangled off the side of the bed with a pillow wedged between the mattress and positioning bedrail and under the resident's right elbow. The resident's right hand and lower right arm was swollen, and appeared shiny and taut (tight, bulging, filled to capacity), his/her right hand was clenched in a fist; -He/She had matted long hair and facial hair. His/Her head rested partially on the mattress and partially on a pillow; -The resident's call light lay on the bed above the resident's left elbow. The resident was unable to reach the call light; -A bedside table was positioned across the resident's knees and upper legs and had two drink cups with handles and an open plastic individual container of juice with no straw or lid. The resident could not reach the drink cups or the open juice container. Observation on 7/25/24 at 10:15 A.M. showed the following: -The resident remained in bed with no change in position, his/her right arm dangled off the side of the bed with a pillow wedged between the mattress and positioning bedrail and under the resident's right elbow. The resident's right hand and lower right arm remained swollen, shiny and taut in appearance with his/her right hand clinched in a fist; -The resident's call light lay on the bed above the resident's left elbow. The resident tried to move his/her left arm to reach the call light. The call light was out of reach; -The bedside table remained across the resident's knees and upper thighs. The resident was unable to reach the drink cups or open juice container; -Housekeeping staff entered the room and arranged the closet, then left the room. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 7/25/24 from 10:16 A.M. to 10:40 A.M. showed the resident remained in bed with no change in position and no staff entered the room. The resident reached for the drinking glass on the bedside table across his/her knees and upper thighs, his/her left hand reached the edge of the bedside table. The resident was unable to reach the drinking glass or obtain a drink. Observation on 7/25/24 from 10:40 to 11:32 A.M. showed the following: -Certified Medication Technician (CMT) A walked into the room and past the resident, adjusted the room air conditioner controls, provided the resident's roommate (Resident #6) a blanket, fresh ice and a soda then left the room. CMT A did not speak to or check on Resident #2; -The resident remained in bed with no change in position, his/her right arm continued to dangle off the side of the bed with a pillow wedged between the mattress and positioning bedrail under the resident's right elbow. The resident's right hand and lower right arm remained swollen, shiny and taut in appearance with his/her right hand clinched in a fist; -The resident's call light lay on the bed out of reach above the resident's left elbow and the resident's head rested partially on the mattress and partially on a pillow; -The bedside table remained across the resident's knees and upper thighs. The resident was unable to reach the drink cups or open juice container. Observation on 7/25/24 at 11:32 A.M. showed the following: -Certified Nurse Assistant (CNA) B and Nurse Assistant (NA) C removed the resident's gown. Soft, loose feces was noted between the resident's legs and perineal skin folds, dried feces was noted between the resident's upper thighs. CNA B and NA C turned the resident to his/her side. The resident's buttocks, hips and perineal skin folds were soiled with loose feces. Four abraded, open areas were noted on the resident's buttocks and tailbone area. Each open area was soiled with feces. Barrier cream was dried and appeared brown in sections, containing feces; -CNA B repeatedly wiped the resident's feces soiled buttocks, skin folds and open abraded areas with wet wipes. The resident yelled out with each wipe; -CNA B applied skin barrier cream over the feces soiled barrier cream and rubbed the cream over the resident's entire buttocks, skin folds and open abraded areas. The resident moaned; -CNA B and NA C repositioned the resident on his/her back and placed the call light in the resident's left hand. CNA B elevated the resident's swollen, shiny and taut right hand on a pillow. The resident's right hand remained clenched in a fist. CNA B and NA C did not provide the resident range of motion or open the resident's right hand and fingers. CNA B and NA C did not offer the resident a drink. The bed side table with the resident's drink cups was out of reach and left against the wall in front of the window. During an interview on 7/25/24 at 11:50 A.M. CNA B said the following: -He/She was responsible for the resident's hall along with NA C. There was no additional CNA staff on the hall; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Valley View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1600 East Rollins St, Moberly, MO 65270	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident needed lots of help, was unable to turn to his/her side and required two staff to provide cares. The resident could drink fluids with supervision but required staff to feed him/her. The resident's right hand was swollen, and staff should keep the resident's right hand elevated on a pillow; -CNA B had not changed the resident or checked on the resident since 7:30 A.M. Feces were dried on the resident. He/She had not provided the resident a drink or any fluids that morning since breakfast; -CNA B and NA C were busy, started rounds at 9:00 A.M. and had not gotten to the resident since 7:30 A.M. The hall was busy, and they had not gotten to the resident any earlier; -The call light was not in reach and the resident was unable to reach his/her drink cups all morning; -He/She should check on the resident at least every two hours, keep the resident clean and dry, reposition the resident and offer a drink. The resident had open wounds and required frequent care. He/She had not provided the resident's care, he/she had not had time earlier in the morning. Observation on 7/25/24 at 12:35 P.M. showed the following: -The resident remained in bed on his/her back, his/her right arm remained elevated on a pillow with his/her right hand clenched in a fist. The resident's right hand and lower right arm remained swollen, shiny and taut in appearance; -The bedside table remained against the wall in front of the window out of the resident's reach. The resident's drink cups remained on the bedside table, untouched; -The resident's mouth appeared dry, flies were noted on the resident's gown, hands and face. Feces were noted on the bottom edge of the resident's gown. Observation on 7/25/24 at 1:45 P.M. showed Licensed Practical Nurse (LPN) D removed the resident's lunch tray. The resident ate a container of ice cream and drank some juice. The resident's gown remained soiled with feces on the bottom edge. His/Her right hand remained swollen, shiny and taught in appearance and was elevated on a pillow with right hand clenched in a fist. The resident's call light was wrapped around the bedrail and hung down the side of the bed out of the resident's reach. Observation on 7/25/24 at 3:30 P.M. showed the resident's family member opened the resident's right hand. The palm of the resident's hand was moist and soiled with three open slits noted in the skin of the resident's palm. The resident's call light remained wrapped around the bedrail and hung down the side of the bed out of the resident's reach. The resident's family member applied a hard plastic right arm splint (a positioning device used to prevent contractures or tightening of the muscles and tendons, caused the fingers to bend to the palm of the hand in a fist) and secured the straps around the back of the resident's right hand near the knuckles and around the resident's forearm. The splint held the resident's right hand in an open position and extended from the resident's fingers to the forearm. The family member elevated the resident's right hand and arm on a pillow. The resident's nails were long with tan debris under the nails. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Health & Rehabilitation	1600 East Rollins St Moberly, MO 65270

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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 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Observation on 7/26/24 at 8:50 A.M. showed the following:

-The resident laid in bed on his/her back, leaning to the right, with his/her right arm secured in a splint, dangling off the edge of the bed. A positioning pillow was tucked under the resident's right elbow and hung off the side of the bed. The right hand and lower arm were swollen, shiny and taut in appearance with the right-hand splint in place. The lower hand strap located at the knuckle was secured tightly and a deep indentation was noted in the swollen hand near the little finger and across the knuckle area;

-The resident's call light hung off the side of the resident's bed out of the resident's reach.

During an interview on 7/26/24 at 9:10 A.M. the Physical Therapy Assistant (PTA) said the resident previously received therapy services and staff should provide range of motion exercises daily. The resident's right-hand splint was intended to prevent contractures. Staff should keep the resident's right hand elevated on a pillow to reduce the swelling.

2. Review of Resident #7's care plan, dated 7/23/24, showed the following:

-admitted [DATE];

-Diagnoses of morbid obesity, lymphedema (excessive swelling of the legs caused by blockage of the lymphatic system), and necrotizing fascitis (a serious bacterial infection that destroys tissue under the skin, flesh-eating disease);

-The resident had an ADL self-care deficit related to limited mobility. Staff should provide extensive assistance with bathing, bed mobility, and dressing. Staff should provide total assistance with toileting, and transfers;

-The resident had potential for and actual impaired skin integrity. Staff should avoid scratching and keep hands and body parts from excessive moisture, keep skin clean and dry, use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface, and use a draw sheet or lifting device to move the resident.

During an interview on 7/25/24 at 9:50 A.M. the resident said he/she came to the facility a few days ago. The evening and night shift were usually slow to answer the call light. He/She was incontinent of bowel and bladder because he/she was in bed. Staff were either too slow or too late answering the call light or the bed pan spilled and the bed became soiled. He/She required a mechanical lift to get out of bed and he/she had a large lower abdominal wound that required dressing changes twice daily. Staff had not changed his/her soiled linens since 5:00 A.M. that morning. He/She had notified multiple staff his/her bed was wet.

Observations on 7/25/24 showed the following:

-At 12:15 P.M. LPN E changed the resident's left lower abdominal wound dressing. The resident said he/she wanted to get up for lunch, his/her bed was wet and had not been changed since 5:00 A.M. that morning. A large brown ring was noted on the bottom sheet extending from under the resident to the resident's right side from mid back to below the knees. A strong urine odor was noted;

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NAME OF PROVIDER OR SUPPLIER Valley View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 East Rollins St Moberly, MO 65270	

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:45 P.M. NA C and the physical therapy assistant (PTA) changed the resident's gown, the resident said he/she was wet and needed cleaned up before getting up in the chair, staff had not cleaned him/her up that morning. NA C and PTA turned the resident to the left side, the resident's bed, bottom sheet, two washable bed protectant pads and turn sheet were saturated with urine. A wadded wet saturated towel lay partially over the urine saturated bed protectant pads. The resident said the night shift covered the wet bed linens with a towel instead of changing the soiled bed protectant pads and sheets in the night. That was about 4:00 A.M. or 5:00 A.M.; -NA C asked if the resident wanted his/her knees wiped. The resident said yes, wash from the knees up, back of his/her legs and all the areas between his/her legs. A red rash was noted between the resident's legs, perineal area skin folds and buttocks; -NA C and PTA provided incontinence care, and a mechanical lift transfer to the wheelchair. 3. During an interview on 7/26/24 at 9:45 A.M. the Director of Nursing (DON) said the following: -Resident #2 had a stroke and had moisture associated skin breakdown on his/her buttocks and tailbone. Staff should apply barrier cream to the open areas and intact skin after providing perineal care and incontinence care. Staff should check the resident every two hours at a minimum and check more frequently if needed. Staff should make sure the resident was clean and dry at all times. The resident's right arm and hand was swollen, and staff should elevate the resident's right arm and hand on a pillow. The resident's right arm and hand should not dangle off the side of the bed. This caused more swelling. Staff should remove the resident's right arm splint and check the resident's skin condition. The splint was new. Staff should provide range of motion to the right arm and hand daily. The DON was not aware the resident had open slits in the palm of his/her right hand from his/her fingernails. Staff should keep the resident's right hand clean and monitor the resident's skin condition. The resident's hand should be kept open with a soft positioning device kept in the palm of the resident's hand to prevent the hand from forming a fist. The resident could get a drink independently if the drink cup was within reach of the resident's left hand and he/she had a lid and straw. The drink cups should always be within the resident's reach; -Staff should check residents frequently, at least every two hours and ensure all residents were kept clean and dry. Residents should not have dried feces between their legs or remain soiled for extended periods of time. Staff should follow the residents care plans and provide all necessary care to keep residents clean, dry and comfortable. Staff should never leave a resident soiled with urine or feces and never cover a urine soiled bed with a towel. Residents call lights should be within reach at all times. During an interview on 7/26/24 at 2:30 P.M. the Administrator said resident should be clean and dry and all Activities of Daily Living met. Staff should complete rounds on all residents at least every two hours and as needed for those who required more frequent care. If staff were behind, they should call for assistance from other halls. There was plenty of staff. Staff should never delay providing cares, should follow the resident's care plans and should avoid leaving residents wet or soiled. Staff should make sure the resident's call light was in reach and the resident was able to use the call light. Staff should provide fluids routinely and offer fluids to those who could not drink or eat independently. He/She expected staff to provide care to meet the residents' needs. MO 238446 (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MO 238672 MO 238666

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35615 Based on observation, interview, and record review, the facility failed to ensure one resident, in a review of seven sampled residents (Resident #2), who had an indwelling urinary catheter (a flexible tube inserted into the bladder to allow urine to drain from the bladder), and who had a history of urinary tract infections (UTI), was provided with urinary incontinence care and indwelling catheter care in a manner to prevent the spread of bacteria that cause infections. The facility had 12 residents with indwelling urinary catheters. The facility census was 84. Review of the facility policy Urinary Catheter Care dated September 2014, showed the following: -The purpose was to prevent catheter-associated urinary tract infections; -Use standard precautions when handling or manipulating the drainage system; -Maintain clean technique when handling or manipulating the catheter, tubing or drainage bag; -Do not clean the periurethral area with antiseptics to prevent catheter-associated urinary tract infections while the catheter was in place. Routine hygiene (cleansing the meatal surface, insertion site, during daily bathing or showering) was appropriate; -Wash the resident's genitalia and perineum thoroughly with soap and water. Rinse the area well and towel dry. Cleanse around the meatus using circular strokes from the meatus (urinary opening) outward, change the position of the washcloth with each cleansing stroke. With a clean washcloth, rinse with warm water using the same technique; -Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward. 1. Review of Resident #2's Physician Order Sheet (POS) dated 6/20/24 showed the following: -Diagnoses included stroke with paralysis of the right side; -Indwelling urinary catheter; -Catheter care every shift; -Macrobid (antibiotic medication) 100 milligrams two times daily for five days for urinary tract infection. Review of the resident's care plan, dated 6/26/24, showed the following: (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had an indwelling urinary catheter. Staff should cleanse the urinary catheter with soap and water, rinse, pat dry every shift and as needed if soiled. Staff should report any signs or symptoms of urinary tract infection such as pain, burning, blood tinged urine, cloudiness, deepening of urine color, decreased or not output, foul smelling urine, altered mental status or change in behavior. Review of the resident's POS, dated 7/4/24, showed an order to send the resident to the emergency department for evaluation and treatment of elevated blood pressure and dysuria (decreased urine output). Review of the resident's emergency room discharge instructions, dated 7/4/24, showed the following: -Diagnosis of urinary tract infection; -Start Bactrim DS (antibiotic medication) 160 mg every 12 hours for 14 days. Review of the resident's Significant Change Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 7/18/24 showed the following: -Severely impaired cognition; -Dependent on staff for personal hygiene; -Required an indwelling urinary catheter (a sterile tube inserted into the bladder used to drain the bladder of urine); -Always incontinent of bowel. Observation on 7/25/24 at 9:45 A.M. showed the resident lay in bed. He/She had an indwelling urinary catheter that contained brown colored urine in the tubing. Observation on 7/25/24 at 11:32 A.M. showed the following: -Certified Nurse Assistant (CNA) B and Nurse Assistant (NA) C removed the resident's gown. Soft, loose feces was noted between the resident's legs and perineal skin folds and around the urinary catheter insertion site. Dried feces was noted between the resident's upper thighs. CNA B wiped both sides of the resident's upper thighs and perineal skin folds with wet wipes removing loose feces. CNA B did not clean around the resident's catheter insertion site or tubing; -CNA B and NA C turned the resident to his/her side. The resident's buttocks, hips and perineal skin folds were soiled with loose feces extended up into the thighs and skin creases between the resident's legs; -CNA B repeatedly wiped the resident's feces soiled buttocks, skin folds and open abraded areas with wet wipes. The resident yelled out with each wipe; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA B and NA C repositioned the resident on his/her back and wiped the resident's upper thighs and the indwelling urinary catheter tubing below the level of the insertion site with wet wipes. Staff did not cleanse the urinary catheter insertion site. Feces was noted near the urinary catheter insertion site. During an interview on 7/25/24 at 11:50 A.M. CNA B said the following: -CNA B had not changed the resident or checked on the resident since 7:30 A.M. Feces was dried on the resident. He/She did not provide perineal care correctly and had not cleansed the resident's urinary catheter tubing or insertion site. He/She should make sure the resident's urinary catheter was kept clean and cleanse feces from the tubing and insertion site to prevent infection. During an interview on 7/26/24 at 9:45 A.M. the Director of Nursing (DON) said staff should follow the residents care plans and provide all necessary care to keep residents clean, dry and comfortable. Staff should provide the resident catheter care every shift and as needed to prevent infections. Staff should keep the urinary catheter clean and cleanse the catheter tubing from the meatus down the tubing. Feces should not be left on the urinary catheter tubing or around the meatus potentially causing a urinary tract infection. The resident had urinary tract infections in the past and was treated with antibiotics. During an interview on 7/26/24 at 2:30 P.M. the Administrator said staff should follow the resident's care plans and provide the resident catheter care as needed and every shift to prevent urinary tract infections. He/She expected staff to meet and provide for the residents' needs and care. MO 238672

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Valley View Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 East Rollins St Moberly, MO 65270	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 35615 Based on observation, interview and record review, the facility failed to ensure nursing staff washed their hands and changed soiled gloves after each direct resident contact and when indicated by professional practices during personal care for one resident (Residents #2), in a review of seven sampled residents. The facility census was 84. Review of the facility policy Handwashing/Hand Hygiene, dated August 2019, showed the following: -The facility considered hand hygiene the primary means to prevent the spread of infections; -All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections; -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors; -Hand hygiene products and supplies shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies; -Wash hands with soap and water when the hands were visibly soiled and after contact with a resident with infectious diarrhea; -Use an alcohol based hand rub or alternatively soap and water for the following situations; -Before and after direct contact with residents; -Before performing any non-surgical invasive procedures; -Before donning gloves; -Before handling clean or soiled dressings; -Before moving from a contaminated body site to a clean body site during resident care; -After contact with a resident's intact skin; -After contact with blood or bodily fluids, -After removing gloves; -Hand hygiene was the final step after removing and disposing of personal protective equipment; -The use of gloves did not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare-associated infections; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265536	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Single use disposable gloves should be used before aseptic procedures, when anticipating contact with blood or body fluids and when in contact with a resident or the equipment or environment of a resident who was on contact precautions. 1. Review of Resident #2's care plan, dated 6/26/24, showed the following: -Diagnoses of stroke with paralysis of the right side, aphasia (difficulty communicating due to damage to the parts of the brain that control language), apraxia (difficulty with skilled movement caused by brain disease or damage), restlessness and agitation, generalized arthritis, and muscle weakness; -The resident was dependent on staff for meeting emotional, intellectual, physical, and social needs related to immobility, physical limitation; -The resident had an Activity of Daily Living (ADL) self-care deficit related to a stroke and was dependent on staff for bathing, bed mobility, dressing, toileting, transfers, eating, and personal hygiene. Staff should allow sufficient time for dressing and undressing and provide simple comfortable clothing. Review of the resident's significant change Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 7/18/24, showed the following: -Severely impaired cognition; -Functional limitation in range of motion, impairment on one side to upper and lower extremity; -Dependent on staff for toileting, bathing, dressing, personal hygiene and transfers; -Required substantial or maximal staff assistance with bed mobility; -Required an indwelling urinary catheter (a sterile tube inserted into the bladder used to drain the bladder of urine); -Always incontinent of bowel. Observation on 7/25/24 at 11:32 A.M. showed the following: -Certified Nurse Assistant (CNA) B and Nurse Assistant (NA) C applied gloves without washing hands and removed the resident's gown. Soft, loose feces was noted between the resident's legs and perineal skin folds and around the urinary catheter insertion site. Dried feces was noted between the resident's upper thighs. CNA B wiped both sides of the resident's upper thighs and perineal skin folds with wet wipes removing loose feces. Feces were noted on CNA B's gloved hands; -CNA B, with the same feces soiled gloves, touched the resident's electronic bed controller and lowered the resident's bed. CNA B, without changing his/her feces soiled gloves, and NA C turned the resident to his/her side. The resident's buttocks, hips and perineal skin folds were soiled with loose feces that extended up into the thighs and skin creases between the resident's legs; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA B, with the same feces soiled gloves, repeatedly wiped the resident's soiled buttocks, skin folds and open abraded areas with wet wipes. CNA B wiped feces directly from his/her gloved hands with wet wipes and did not change his/her soiled gloves or wash his/her hands; -CNA B, with the same feces soiled gloves, applied clean linens to the resident's bed, applied skin barrier cream to his/her feces soiled gloved hands and rubbed the skin barrier cream into the resident's open abraded buttock areas and onto intact skin; -CNA B, with the same feces soiled gloves, and NA C repositioned the resident on his/her back touching the resident's arms, legs, hips, and bed linens. During an interview on 7/25/24 at 11:50 A.M. CNA B said the following: -He/She was responsible for the resident's hall along with NA C. The resident needed lots of help, was unable to turn to his/her side and required two staff to provide cares; -Feces were dried on the resident. He/She did not wash his/her hands or change gloves correctly. He/She should wash his/her hands when entering a resident's room and before putting on gloves. He/She should change gloves anytime the gloves were soiled and not attempt to wash feces off the soiled gloves with wet wipes. He/She should have changed gloves and washed his/her hands when the gloves were soiled and before applying clean linens and touching other items in the resident's room. He/She should not apply skin barrier cream on the resident's open abraded skin and intact skin with feces soiled gloves; -Handwashing prevented infections. He/She should provide resident care with clean hands and clean gloves. During an interview on 7/26/24 at 9:45 A.M. the Director of Nursing (DON) said staff should follow the resident's care plans and provide all necessary care to keep residents clean, dry and comfortable. Staff should wash hands and apply gloves prior to providing resident cares and change gloves any time the gloves were soiled. Staff should wash hands or use hand sanitizer every time gloves were changed to prevent the spread of infections. During an interview on 7/26/24 at 2:30 P.M. the Administrator staff should follow the facility policy regarding hand washing and gloving to prevent infections. MO 239243