

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265554	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2024
NAME OF PROVIDER OR SUPPLIER Meramec Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Mattox Drive Sullivan, MO 63080	

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)
<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18236</p> <p>Based on interview and record review, facility staff failed to maintain an infection prevention and control program to provide a safe and sanitary environment to help prevent potential spread of COVID-19 (an acute respiratory illness in humans caused by the coronavirus, SARS-CoV-2 and other infections), when staff failed to separate rooms for one resident (Resident #2) who tested negative on 08/07/24 after the residents roommate (Resident #1) tested positive for COVID on 08/07/24. Resident #2 remained in the same room with Resident #1 and tested positive for COVID on 08/10/24. The facility census was 45.</p> <p>Review of Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated March 18, 2024, showed a patient with suspected or confirmed SARS-CoV-2 infection should be placed in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom. If cohorting, only patients with the same respiratory pathogen should be housed in the same room.</p> <p>Review of the facility's COVID-19 Action Plan, updated 5/22/23, showed based on Infection Prevention and Control recommendations from the Centers for Disease Control, Centers for Medicare and Medicaid Services, and World Health Organization a resident with suspected or confirmed SARS-CoV-2 infection should be placed in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom. If cohorting, only patients with the same respiratory pathogen should be housed in the same room.</p> <p>1. Review of the facility bed listing showed Resident #1 who tested positive for COVID on 8/7/24, and Resident #2 who tested negative for COVID on 8/7/24 in room [ROOM NUMBER] together.</p> <p>Review of Resident #1's COVID-19 test result, dated 8/7/24, showed staff documented the resident tested positive for COVID.</p> <p>Review of Resident #2's COVID-19 test result, dated 8/7/24, showed staff documented the resident tested negative for COVID.</p> <p>Review of Resident #2 COVID-19 test result, dated 8/10/24, showed staff documented the resident began to have a cough and congestion and tested positive for COVID.</p> <p>(continued on next page)</p>

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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NAME OF PROVIDER OR SUPPLIER Meramec Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 940 Mattox Drive Sullivan, MO 63080	
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<p>F 0880</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/19/24 at 11:56 A.M., Resident #2's family member said he/she would have expected staff to separate his/her family member to another room if the roommate tested positive for COVID. He/She said the resident had a cough and congestion in his/her lungs starting the day prior to him/her testing positive for COVID and the symptoms continue to this day.</p> <p>During an interview on 8/14/24 at 12:27 P.M., the administrator said Resident #1 tested positive for COVID 8/7/24 and the roommate, Resident #2, who remained in the room, tested positive on 8/10/24.</p> <p>During an interview on 8/14/24 at 12:19 P.M., Assistant Director of Nursing (ADON)/Infection Preventionist said Resident #2 had sinus congestion and was running a fever on the day the resident tested positive for COVID.</p> <p>During an interview on 8/14/24 at 12:27 P.M., the administrator said she misunderstood the policy before and said a resident testing positive could be in a room with another resident who tested positive, but not a roommate who tested negative for COVID. She said they had left Resident #1 and Resident #2 in the same room because they thought since Resident #2 had been exposed then he/she could stay in the room with Resident #1 who tested positive for COVID.</p> <p>During an interview on 8/14/24 at 12:52 P.M., ADON said he/she was the infection preventionist and had been for three months. He/She said he/she looked at the facility policy on COVID, but it was a little confusing. He/She thought a roommate who tested negative should remain in a room with a resident who tested positive, because they had already been exposed and this is what they did when one tested positive for COVID but the roommate was negative. ADON said when residents remained in the room together, they did not wear masks they just had the curtain pulled. He/She said now he/she realizes the roommate who tests negative should not remain in the room but be separated to another area.</p> <p>During an interview on 8/19/24 at 12:22 P.M., administrator said if a resident tested positive for COVID, she expected staff to remove a roommate who tests negative to another room alone or to another room with another resident who tested negative but may have been exposed to a resident who tested positive. She said it was not done per the policy with Resident #1 and Resident #2 because she had misunderstood the policy initially.</p> <p>MO00240550</p>		