STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakdale Care Center	2702 Debbie Lane Poplar Bluff, MO 63901

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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a facility-initiated transfer when one resident (Resident #49) out of one sampled resident transferred to the hospital. The facility census was 55. Review of the facility's policy titled, Making an Emergency Transfer or Discharge, dated December 2016, showed: - Notify the receiving facility; - Prepare the resident; - Prepare a transfer form to send with the resident; - Notify the resident representative; - The policy did not address notification in writing to the resident or the resident representative. 1. Review of Resident #49's medical record showed: - Resident transferred to the hospital for medical evaluation on 10/16/24, and readmitted to the facility on [DATE]; - No documentation of the written notification to the resident and/or the resident's representative of the resident's transfer to the hospital on 10/16/24. During an interview on 10/24/24 at 10:01 A.M., Licensed Practical Nurse (LPN) A said the charge nurse was responsible for completing the transfer/discharge form. If the resident was unable to sign, the family or guardian was called by two nurses and then the form was sent out later by social service. During an interview on 10/24/24 at 10:03 A.M., LPN B said the resident's nurse filled out the transfer/discharge notification and the resident signed if able. If not, the family was notified and social service sent the notification to them to sign and return. (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: 265556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Oakdale Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 Debbie Lane Poplar Bluff, MO 63901	

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/24/24 at 10:05 A.M., the Assistant Director of Nursing said the transfer/discharge was explained to the resident if they were alert and they sign it. If they weren't alert, the representative was notified and explained. Two nurses should witness, and the form should be left with the shift communication logs. The form was then sent to the resident representative. During an interview on 10/24/24 at 10:15 A.M., the Administrator said nursing was responsible for completion of the transfer/discharge notification. If the resident was unable to sign it, two nurses should contact the resident representative and explain it to them, both nurses should sign, and it was then sent to the representative. It should all be documented. During an interview on 10/24/24 at 11:00 A.M., the Social Services Designee said the transfer/discharge notifications were sent out as soon as possible after he/she got them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37575 Based on interview and record review, the facility failed to inform the resident, family, and/or legal representative of their bed hold policy in writing at the time of transfer to the hospital for one resident (Resident #49) out of one sampled resident. The facility's census was 55. The facility did not provide a policy related to bed hold notification. 1. Review of Resident #49's medical record showed: - Transferred and admitted to the hospital on 10/16/24, and readmitted to the facility on [DATE]; - No documentation the resident or the resident's representative was informed in writing of the facility bed hold policy at the time of transfer. During an interview on 10/24/24 at 10:01 A.M., Licensed Practical Nurse (LPN) A said the charge nurse was responsible for completing the bed hold form if the resident was unable to sign the family or guardian was called by two nurses and then the form was sent out later by social service. During an interview on 10/24/24 at 10:03 A.M., LPN B said the resident's nurse filled out the bed hold notification and the resident signed if able. If not, the family was notified, and social service sent the notification to them to sign and return. During an interview on 10/24/24 at 10:05 A.M., the Assistant Director of Nursing (ADON) said the bed hold was explained to the resident if they were alert, and if able they were able sign it. If not, the representative was notified and it was explained. Two nurses should witness and the form should be left with the shift communication logs. It was then sent to the resident representative. During an interview on 10/24/24 at 10:15 A.M., the Administrator said nursing was responsible for completion of the bed hold notification. If the resident was unable to sign it, two nurses should contact the resident representative and explain it to them, both nurses should sign, and it was sent to the representative. It should all be documented. During an interview on 10/24/24 at 11:00 A.M., the Social Services Designee said the bed hold notifications were sent out as soon as possible after he/she got them.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 45693 Based on interview and record review, the facility failed to complete a comprehensive discharge summary for one resident (Resident #54) out of one discharged resident. The facility's census was 55. The facility did not provide a policy regarding a discharge summary or recapitulation. 1. Review of Resident #54's closed medical record showed: - Resident discharged home on 08/10/24; - No documentation of a discharge summary or recapitulation. During an interview on 10/24/24 at 10:11 A.M., the Administrator said there was no discharge or recapitulation done for the resident. It should have been done. Social services was responsible for this and discharge planning should be started as soon as the residents were admitted . During an interview on 10/24/24 at 11:00 A.M., the Social Services Designee said the resident didn't get the discharge summary or recapitulation did but should have. He/She missed completing the discharge summary and was responsible.

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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. 45693 Based on observation, interview and record review, the facility failed to ensure a urinary catheter (a tube inserted into the bladder to drain urine) drainage bag and tubing was kept off the floor for two residents (Residents #9 and #21), failed to cover a urinary catheter drainage bag with a dignity bag for one resident (Resident #21), and failed to ensure proper urinary catheter placement when staff raised the catheter drainage bag and tubing above the level of the bladder for one resident (Resident #9) out of two sampled residents. The facility census was 55. Review of the facility's policy titled, Catheter Care, Urinary, revision date July 2017, showed: - Be sure the catheter tubing and drainage bag are kept off the floor. 1. Review of Resident #9's medical record showed: - Diagnoses of primary lateral sclerosis (the breakdown of nerve cells causes weakness in the muscles that control the legs, arms and tongue), neuromuscular dysfunction of the bladder (a condition that occurs when the nerves and muscles of the bladder don't work together properly), quadriplegia (a symptom of paralysis that results in the complete or severe loss of motor function in all four limbs and the body from the neck down), and cystostomy (a surgical procedure that creates a connection between the bladder and the skin to drain urine) status. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed: - An order for suprapubic catheter (a tube that drains urine from the bladder by creating a surgical connection between the bladder and the skin in the lower abdomen) change every month and as needed (PRN) between the 14th and 17th of the month, dated 12/16/21; - An order for catheter care every shift, dated 06/29/23. Observations of the resident showed: - On 10/23/24 at 8:50 A.M., the resident sat in a wheelchair and the catheter drainage bag hung under the wheelchair on the frame and touched the wheel and the bottom of the bag touched the floor; - On 10/23/24 at 10:30 A.M., the resident sat in a wheelchair and the catheter drainage bag hung under the wheelchair on the frame and rested against the wheel. Observation on 10/23/24 at 11:00 A.M., showed: - Certified Nursing Assistant (CNA) D emptied the catheter drainage bag; - CNA D lifted the catheter drainage bag above the level of the resident's bladder; - The urine in the tubing drained back toward's the resident's bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #21's medical record showed: - Diagnoses of chronic kidney disease (CKD - a condition in which the kidneys are damaged and cannot filter blood as well as they should), benign prostatic hyperplasia (BPH - enlargement of the prostate causing difficulty in urination), retention of urine (a condition in which the bladder doesn't empty completely even if full), urinary tract infection (an infection in your urinary system), neuromuscular dysfunction of the bladder, and neurogenic bladder (condition that results in lack of bladder control due to a brain, spinal cord or nerve problem). Review of the resident's POS, dated October 2024, showed: - An order for catheter care every shift, dated 03/17/23; - An order to change the catheter bag PRN, dated 03/17/23; - An order to change the 16 French (size of the catheter) Coude (type of catheter that have a bend at the distal tip) suprapubic catheter monthly between the 1st and 5th and PRN for occlusion, dated 02/17/24. Observations of the resident showed: - On 10/21/24 at 9:04 A.M., 10:05 A.M., and 11:29 A.M., the resident sat in in his/her room in a wheelchair, the catheter drainage bag hung under the wheelchair on the frame, the bottom of the bag touched the fall mat, six inches of the catheter tubing lay on the floor, and no privacy cover in place with the catheter drainage bag visible from the hall; - On 10/21/24 at 11:38 A.M., staff propelled the resident in a wheelchair to the dining room and the bottom of the catheter drainage bag and the tubing drug the floor under the wheelchair, no privacy cover in place with the catheter drainage bag visible to other residents, family members, and staff. After the resident was placed at a table, the bottom of the drainage bag and the tubing touched the floor; - On 10/21/24 at 12:20 P.M., the resident sat in the dining room in a wheelchair, the catheter drainage bag hung under the wheelchair on the frame, four inches of the catheter tubing lay on the floor, and no privacy bag in place with the catheter drainage bag visible to other residents, family members, and staff; - On 10/21/24 at 2:30 P.M., the resident lay in a low bed low, the catheter drainage bag hung on the bed frame with a privacy cover in place, the bottom of the drainage bag lay on the floor, and the coiled tubing lay on the floor; - On 10/22/24 at 11:48 A.M., the resident propelled the wheelchair from his/her room, through the hall, through the common area, and to the dining room. The catheter tubing drug on the ground under the wheelchair where it hung from under the wheelchair on the frame and with a privacy cover in place. Staff assisted the resident to the dining room table with the bottom of the catheter drainage bag exposed from under the privacy cover and the tubing lay on the floor; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 10/22/24 at 12:22 P.M., the resident sat in the dining room in the wheelchair, the catheter drainage bag hung under the wheelchair on the frame, and the bottom of the catheter drainage bag, exposed from under the privacy cover and the tubing touched the floor; - On 10/23/24 at 10:00 A.M., 10:56 A.M., and 2:58 P.M., the resident lay in a low bed, the catheter drainage bag hung on the bed frame with a privacy cover in place, and the bottom of catheter drainage bag along with four inches of the catheter tubing lay on the floor. During an interview on 10/24/24 at 10:30 A.M., CNA D said the catheter drainage bag shouldn't touch the wheels or the floor. The tubing shouldn't either. The catheter, the catheter drainage bag, or the tubing shouldn't be raised above the resident's bladder. During an interview on 10/24/24 at 11:00 A.M., Licensed Practical Nurse (LPN) B said the catheter drainage bag and tubing shouldn't touch the floor or anything. The catheter, the catheter drainage bag, or the tubing shouldn't be raised above the resident's bladder level. During an interview on 10/24/24 at 11:15 A.M., the Director of Nursing (DON) said catheter drainage bags or tubing should not touch the floor or any objects. The catheter, the catheter drainage bag, or the tubing should never be raised above the level of the resident's bladder. All staff were responsible to check placement of the catheter drainage bags and tubing when walking by or doing care. During an interview on 10/24/24 at 12:15 P.M., the Administrator said a catheter drainage bag or tubing shouldn't touch anything. The catheter, the catheter drainage bag, or the tubing should never go above the level of the resident's bladder. All staff should check placement of catheter drainage bags and tubing . 47445

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	265556	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakdale Care Center	2702 Debbie Lane Poplar Bluff, MO 63901

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 47445 Based on observation and interview, the facility staff failed to post the required daily nurse staffing information which included the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, in a prominent location readily accessible to residents and visitors. The facility census was 55. Review of the facility policy titled, Daily Staffing Information, dated July 2014, showed: -It is the policy of the facility, as required by Centers for Medicare and Medicaid Services (CMS), to post daily staffing information in the facility. This must be posted in a prominent place, readily accessible to residents and visitors at the start of each shift; - Staffing is to be posted daily utilizing a standardized form that includes the facility name, current date, total number of staff and actual hours worked; - Each facility should complete the Daily Staffing Information form indicating the actual hours worked by staff; - The staffing information form should be posted in the facility in a clearly visible place or places that are accessible to facility staff, patients, and visitors. Observation on 10/21/24 at 9:16 A.M., the facility's Nurse Staffing information located on a white board behind the nurse's station, showed: -Did not include total number of staff and actual hours worked by both licensed and unlicensed nursing staff; -Did not show unlicensed nursing staff directly responsible for resident care. Observations on 10/22/24 at 9:00 A.M. - 3:30 P.M., 10/23/24 at 8:15 A.M. - 4:30 P.M., and 10/24/24 at 7:54 A.M., showed: - The white board was blank; - The facility did not post the required daily nurse staffing information. During an interview on 10/24/24 at 8:01 A.M., the Director of Nursing (DON) said the white board behind the nurse's station was used for the required daily nurse staffing information. The posted information didn't include unlicensed nursing staff. During an interview on 10/24/24 at 12:16 P.M., the Administrator said there was a white board at the nurse's station outlined to show the date, census, and the nursing staff. It should be filled out daily and should be changed when the morning shift came in daily. Unlicensed nursing staff should be included on the white board.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45693 Based on observation, interview, and record review, the facility failed to store medications in a safe and effective manner. This had the potential to affect all residents. The facility census was 55. Review of the facility's policy titled, Insulin Pen Injection Administration, dated June 2020, showed: - Follow manufacturer instructions for expiration dating. Review of Lantus (a type of insulin) manufacturer's insert, dated 08/2022, showed to discard the Lantus pen after 28 days of opening, even if it has insulin in it. 1. Observation on 10/23/24 at 10:02 A.M., of the nurse medication cart showed two Lantus pens labeled with an opened date of 09/21/24, 32 days after opening. During an interview on 10/24/24 at 9:45 A.M., the Corporate Registered Nurse (RN) said the facility's policy was to follow the manufacturer insert since different insulins were good for different amounts of days after opened. During an interview on 10/24/24 at 10:50 A.M., Licensed Practical Nurse (LPN) B said insulin pens should be dated and discarded within the designated time frame. During an interview on 10/24/24 at 11:00 A.M. the Assistant Director of Nursing (ADON) said Lantus was good for 30 days once opened and should be discarded in the sharps container once that time frame was reached. During an interview on 10/24/24 at 11:10 A.M., the Administrator said it was expected that nurses would follow the policy in regards to how long an insulin pen was opened for.

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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. 45693 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 55. Review of the facility's policy titled, Food Labeling, revised January 2012, showed: - Foods must be properly labeled; - Write time and date of preparation on a label and place on the container. The facility did not provide policies regarding kitchen cleaning, meal carts, or covering of foods. 1. Observation on 10/21/24 at 9:28 A.M., and 10/22/24 at 8:59 A.M., of the kitchen showed: - No cleaning logs; - Scattered debris below the food preparation table on the shelf under the table; - Cooking sheet attached to the stove separating the fryer and the cooking stove to be dirty and covered in grease; - 20 fluorescent lights in the kitchen area without covers. 2. Observation on 10/21/24 at 9:28 A.M., and 10/22/24 at 8:59 A.M., of the preparation and cooking area showed: - The cooked/prepped food refrigerator with bags of greens, grapes, tomatoes, and onions all in quart bags, and an opened bag of turkey lunch meat, undated; - The freezer with three individually wrapped pizza sticks and an open bag of hot dogs, undated; - The bread shelf with two opened loaves of bread and one package of opened hotdog buns, undated. 3. Observation on 10/21/24 at 9:28 A.M., and 10/22/24 at 8:59 A.M., of the dry food pantry showed: - One half used package of chocolate chips, undated; - One half used bottle of cooking wine, undated; - One opened bag of sprinkles, butterscotch chips, and backing cocoa, undated; - One half used 128 ounce (oz) bottle of barbecue sauce, undated; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- One quarter used one gallon bottle of Worcestershire sauce, undated; - One opened five pound bag of buttermilk biscuit mix, undated; - One gallon storage bag of breadcrumbs, not labeled and undated; - The freezer labeled potatoes had a half bag of french fries, undated; - The freezer labeled waffles had a big bag of uncooked waffles, undated; - One gallon bag of waffles in the refrigerator, undated; - The freezer with five sausages in a bag, undated; - A gallon bag of lasagna noodles frozen, not labeled and undated. 4. Observation on 10/21/24 at 12:13 P.M., of the 100 Hall meal cart pushed down the 100 Hall showed 10 cups and two bowls of cake not covered. 5. Observation of the 300/400 Hall meal cart pushed down the halls showed: - On 10/21/24 at 12:14 P.M., seven uncovered plates of cake and 15 uncovered drinks; - On 10/24/24 at 12:38 P.M., two bowls of uncovered cookies and 11 uncovered drinks. During an interview on 10/24/24 at 11:00 A.M., the Dietary Manager (DM) said he/she asked about the uncovered lights and was told new bulbs were put in at some point and the covers were just not put back on. There shouldn't be crumbs on any shelving and the pan beside the fryer and the fryer area did need to be cleaned. All food items should be dated and labeled once opened. During an interview on 10/24/24 at 12:00 P.M., the Administrator said she would expect the kitchen staff to follow policies, everything to be dated and labeled, and areas kept clean. During an interview on 10/24/24 at 12:40 P.M., the Assistant director of Nursing (ADON) said all food and drinks on the hall carts should be covered. During an interview on 10/24/24 at 12:50 P.M., the DM said food and drinks on the hall carts should be covered. During an interview on 10/24/24 at 1:01 P.M., Certified Nursing Assistant (CNA) C said the food and drinks on the hall cart should be covered. Whoever prepared the food or drink should cover them.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45693 Based on observation, interview, and record review, the facility failed to ensure a dumpster was closed at all times and maintained to keep pests out and/or to keep the garbage contained in the dumpster. The facility census was 55. The facility did not provide a policy in regards to the dumpster. Observations of the outside trash dumpster showed: - On 10/21/24 at 11:33 A.M., the dumpster lid opened with three bags above the top of the dumpster opening; - On 10/21/24 at 3:00 P.M., the dumpster lid opened; - On 10/22/24 at 9:30 A.M., the dumpster lid opened. Staff walked with a cart of trash, placed the trash in the dumpster, and did not close the dumpster lid; - On 10/22/24 at 10:10 A.M., the dumpster lid opened; - On 10/22/24 at 12:49 P.M., the dumpster lid opened; - On 10/23/24 at 11:00 A.M., the dumpster lid opened; - On 10/24/24 at 8:30 A.M., the dumpster lid opened; - On 10/24/24 at 8:30 A.M., around the dumpster showed a twenty foot radius of debris including gloves, masks, plastic, paper, and plastic silverware lay on the ground; - On 10/24/24 at 8:30 A.M., a black trash bag containing kitchen trash lay on the ground between the two recycling dumpsters with cardboard in them. During an interview on 10/24/24 at 11:00 A.M., the Dietary Manager (DM) said the dumpster lid should be closed after discarding trash. During an interview on 10/24/24 at 11:10 A.M., the Maintenance Director said the dumpster lid should be closed after staff put trash in it. If trash was dropped out when putting trash in the dumpster, staff should pick it up. All staff were responsible for keeping the trash area clean. There shouldn't be trash on the ground. During an interview on 10/24/24 at 12:00 P.M., the Administrator said trash should not be on the ground around the dumpster and the dumpster lid should always be closed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265556	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Oakdale Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 Debbie Lane Poplar Bluff, MO 63901	

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. 45693 Based on observation, interview, and record review, the facility failed to use proper infection control techniques during incontinent care for four residents (Residents #9, #21, #48 and #205) out of four sampled residents and one resident (Resident #3) outside the sample. The facility failed to properly store trash and regulated medical waste boxes filled with biohazard material. The facility also failed to use proper infection control techniques during trash disposal. The facility census was 55. Review of the facility policy titled, Handwashing, dated April 2015, showed: - It is the policy that all staff thoroughly cleanse hands with friction, soap, and water to control infection and reduce transmission of organisms; - Hands should be thoroughly washed before and after providing resident care. Review of the facility policy titled, Perineal Care, dated July 2017, showed: - The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition; - Place the equipment on the beside stand; wash and dry hands thoroughly; - Put on gloves, wet washcloth and apply soap or skin cleansing agent; - Wash the perineal area, including thighs, do not reuse the same washcloth; - Wash the rectal area, dry area; - Discard disposable items, remove gloves, wash and dry hands; - Reposition the bed covers, clean the bedside stand, wash and dry hands. Review of the facility policy titled, Catheter Care, Urinary, revised 07/2017, showed: - The purpose is to prevent catheter-associated urinary tract infections; - Be sure the catheter tubing and drainage bag are kept off the floor. Review of the facility policy titled, Isolation, dated April 2015, showed: - It is the policy that residents whose medical condition warrants it will be placed in isolation following the Center for Disease Control and Prevention (CDC) guidelines and physician orders to further prevent the possible spread of infection; (continued on next page)

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	265556	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakdale Care Center	2702 Debbie Lane Poplar Bluff, MO 63901

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- If there is a reason to believe that a resident has an infectious or communicable disease, the charge nurse shall immediately notify the resident's attending physician for appropriate isolation instruction; - The order shall be entered on the Physician Order Sheet (POS); - Isolation procedures shall remain in effect until discontinued by the attending physician; - Refer to the current CDC guidelines regarding isolation requirements; - Appropriate isolation equipment and supplies will be gathered and placed outside the resident's room, isolation barrels will be placed inside the resident's room; - An isolation room is identified by an appropriate sign posted on the room entrance door informing visitors to see the nurse before entering; - The charge nurse is responsible for completing the isolation checklist; - The charge nurse shall notify the director of housekeeping/laundry of the isolation. Review of the facility policy titled, Isolation Precautions/Enhanced Barrier Precaution (EBP), dated 03/20/24, showed: - EBP refers to an infection control intervention designed to reduce transmission of multi drug-resistant organisms (MDRO) that employ targeted gown and glove use during high contact resident care activities; - EBP is used in conjunction with standard precautions and expand the use of PPE to putting on a gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing; - EBP are indicated for residents with any of the following: infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO; - EBP should be used when staff do the following care for the resident: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use such as a central line, urinary catheter (a tube inserted into the bladder to drain urine), feeding tube (a tube inserted into the stomach for feeding and medication administration), tracheostomy/ventilator; wound care with any skin opening requiring a dressing. The facility did not provide a policy regarding infection control practices for trash and medical waste storage and disposal. 1. Observation on 10/22/24 at 10:10 A.M., of Resident's #3's incontinent care showed: - Certified Nursing Assistant (CNA) G and CNA H entered the resident's room, did not perform hand hygiene, and put on gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA G wet two washcloths and lay the wet washcloths on the bedside table without a barrier; - CNA G and CNA H unfastened the brief, lowered resident's pants, and CNA G removed the gloves, did not perform hand hygiene, and put on gloves; - CNA G retrieved a washcloth from the bedside table, cleaned the peri area, lay the soiled washcloth on top of the clean washcloth on the bedside table, picked up the same soiled wash cloth from the bedside table and wiped the resident's buttocks, changed gloves, and did not perform hand hygiene; - CNA G placed a clean brief under the resident; - CNA G moved the bed back against the wall, placed a pillow under the resident's feet, covered the resident with linens, gave the resident the call light, and adjusted the head of the bed with the crank handle at the foot of the bed. 2. Observation on 10/23/24 at 9:55 A.M., of Resident #9's incontinent care showed: - CNA D and CNA E entered the resident's room, did not perform hand hygiene, and put on gloves; - CNA D wet washcloths; - CNA D removed the resident's brief soiled with urine and cleansed the buttocks; - CNA D dropped the wet washcloth on the floor and on top of his/her shoe; - CNA D didn't change gloves, didn't perform hand hygiene, used another washcloth and cleansed the groin folds; - CNA D dropped the wet washcloth on the floor and on top of his/her shoe; - CNA D used another wet washcloth and cleansed the groin; - CNA D dropped the wet washcloth on the floor and on top of his/her shoe with the others; - CNA D didn't change gloves, didn't perform hand hygiene, helped CNA E apply a new brief, pulled up the resident's pants, and assisted the resident in a chair. During an interview on 10/23/24 at 2:45 P.M., CNA D said hands should be washed at the start and at the end of care. Gloves should be changed when going from dirty to clean care. During an interview on 10/23/24 at 10:10 A.M., Licensed Practical Nurse (LPN) B said hands should be washed at the start and end of incontinent care and when going from dirty to clean care. 3. Observation on 10/22/24 at 9:57 A.M., of Resident #21's incontinent and suprapubic (a type of indwelling catheter) catheter care showed: - CNA G entered the room, did not perform hand hygiene, did not put on a gown and gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA G unhooked the catheter drainage bag from the wheelchair frame, lay it on the floor, picked up the catheter drainage bag. hooked it on the bed frame. and the bottom of the catheter drainage bag and tubing touched the floor; - CNA G did not perform hand hygiene, put on gloves, lowered the resident's pants, unfastened and lowered the brief soiled with fecal material between the resident's legs; - CNA G did not change gloves, did not perform hand hygiene, removed the wipes from the wipe package, and lay the wipes on top of the opened package on the bed; - CNA G did not change gloves, did not perform hand hygiene, picked up a wipe up off the opened package on the bed, and wiped the skin around the suprapubic catheter; - CNA G did not change gloves, did not perform hand hygiene, picked up a wipe up off the opened package on the bed, wiped from the catheter insertion point down, wiped the catheter three times with the same area of the wipe, and did not change gloves and did not perform hand hygiene between each wipe; - CNA G did not change gloves, did not perform hand hygiene, assisted the resident to roll to the side, picked up a wipe up off the opened package on the bed, cleaned the fecal material from the buttocks; - CNA G did not change gloves, did not perform hand hygiene, placed a clean brief under the resident, fastened the brief, pulled the resident's pants up, lay the opened wipe package on the nightstand, and touched the bed sheet, the blanket and the call light. During an interview on 10/22/24 at 10:28 A.M., CNA G said hands should be washed or sanitized prior to resident care and putting on gloves. When performing catheter care, should wear PPE of gloves and a gown. For suprapubic catheter care, should clean the skin around the tubing, tubing, and clean the catheter tubing away from the opening. Should change gloves and sanitize hands between the catheter care and a new area, and when moving from dirty to clean care. The catheter drainage bag and tubing should not touch the floor. No items should be placed on the floor and dirty items should be placed in a bag. 4. Observation on 10/22/24 at 11:00 A.M., of Resident #21's incontinent and catheter care showed: - CNA E did not perform hand hygiene, put on gloves and a gown, wet the washcloths with peri cleanser, lay the wet washcloths on the nightstand without a barrier; - CNA E lowered the resident's pants, unfastened the brief, provided catheter care, dropped the soiled wet wash cloth on the floor, changed gloves, and sanitized hands; - CNA E cleaned fecal material from the buttocks, placed the brief soiled with fecal material on the floor, placed the soiled washcloth on top of the brief on the floor, did not change gloves, did not perform hand hygiene, retrieved a washcloth from the nightstand, removed gloves and placed them on the floor, wiped his/her bare hands with a paper towel, did not perform hand hygiene, and put on gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA E placed a clean brief under the resident, removed the soiled incontinent pad from the bed and placed it on the floor; - CNA did not change gloves, did not perform hand hygiene, fastened the brief, pulled the resident's pants up, and put shoes on the resident; - CNA E picked up the soiled brief and gloves from the floor and placed in a trash container; - CNA E placed the soiled washcloths inside the soiled incontinent pad left on the floor, removed the gown and gloves, and sanitized hands; - CNA E exited the room, retrieved trash bags, entered the room, did not perform hand hygiene, did not put on gloves, used an opened trash bag to pick up the soiled linens from the floor, removed the trash bag from the trash container, placed the trash bag on the floor, and placed a new bag in the trash container; - CNA E did not perform hand hygiene, did not put on gloves, assisted the resident to sit on the side of the bed, transferred the resident to the wheelchair, removed the catheter drainage bag from the bed frame to the wheelchair frame, straightened the bed linens on the bed, retrieved the trash bags with the trash and the soiled items from the floor, did not perform hand hygiene, exited the resident's room, took the trash bags to the barrels at the end of the hall, did not perform hand hygiene, entered another resident's room, turned off the call light, exited the resident's room with that resident's water cup, did not perform hand hygiene, pushed Resident #21 in the wheelchair to the common area, did not perform hand hygiene, touched the pitcher of tea in the dining room, filled the other resident's cup with his/her bare hands with tea, walked back down the hall, did not perform hand hygiene, entered the other resident's room and provided the cup of tea to the other resident, did not perform hand hygiene, and pushed the other resident in the wheelchair to the dining room. During an interview on 10/24/24 at 11:00 A.M., CNA E said the catheter drainage bag should hang on the side of the bed frame and should not drag the floor or be tugged on. If a resident was in a wheelchair, the catheter drainage bag should be placed under the wheelchair on the frame so it doesn't get caught on the resident's feet or drag the floor, and there should be a privacy cover on it at all times. The tubing should not touch floor at any time. During incontinent care, he/she should change gloves and sanitize hands if gloves were visibly dirty and when moving from dirty to clean care, should wash hands before care and when done with care, carry out trash and dirty linens in bags, and sanitize or wash hands again. Soiled items should go in a bag and not lay on the floor, nothing should go on the floor. Should sanitize or wash hands between residents and between rooms. Should sanitize hands after any interactions with residents or resident items. Gloves and gown should be worn during care of residents with catheters, there should be a sign on the door showing contact precautions or EBP, and PPE should be in containers outside the resident's door. 5. Observation on 10/24/24 at 2:05 P.M., of Resident #48's incontinent care showed: - CNA D and CNA F did not perform hand hygiene and put on gloves; - CNA D and CNA F transferred the resident from the geri-chair (a reclining chair on wheels) to the bed on top of two incontinent pads; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA D and CNA F staff assisted the resident to remove his/her urine soaked clothes; - CNA D unfastened and removed the resident's urine soaked brief; - CNA D cleaned the resident's front peri area; - CNA D did not perform hand hygiene, did not change gloves, and cleaned the resident's left buttock and hip; - CNA D did not clean the resident's right buttock and hip; - CNA D changed gloves, did not perform hand hygiene, and applied cream to the resident's buttocks. During an interview on 10/24/24 at 2:15 P.M., CNA D said all parts of the resident should be cleaned and hands should be cleaned prior to putting on gloves. 6. Review of Resident #205's Progress Notes showed: On 10/18/24 the resident had extended-spectrum beta-lactamase (ESBL - enzymes produced by some bacteria that may make them resistant to some antibiotics) the in sputum and urine and was on contact precautions; - On 10/19/24, the resident remained in his/her room on isolation for ESBL and methicillin-resistant Staphylococcus aureus (MRSA - a type of infection that can be resistant to several antibiotics) in the sputum. Observation on 10/23/24 at 9:04 A.M., of Resident #205's incontinent care showed: - CNA D and CNA E did not perform hand hygiene, put on a gown, gloves, and a mask with an eye shield, entered the resident's open door of the room with signage on the door showed EBP precautions, and closed the door; - CNA D and CNA E assisted the resident to the toilet in the shared bathroom and lowered the resident's pants and brief; - CNA D used a wet washcloth to wipe fecal material from the resident's buttocks, draped the washcloth with the fecal material folded inside of it over the side of the trash can in the shared bathroom, did not perform hand hygiene, did not change gloves, touched the toilet handle, assisted the resident to transfer from the toilet, removed the gloves and gown, did not perform hand hygiene, touched the bedside table, touched the door handle of the room, and performed hand hygiene; - CNA E removed the gloves, gown, and the mask with the eye shield, performed hand hygiene, put on gloves, tied the red biohazard trash bag in the regulated medical waste box, left the box open without the lid, did not remove gloves, did not perform hand hygiene, left the room with the opened box, walked to the emergency eye wash station room, touched the outside door knob with gloved hands, removed the biohazard trash bag from the opened box, sat the opened box near the eye washing station, removed the gloves, and touched the inside door knob of the emergency eye wash station room; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA D put on gloves and a gown; tied the red biohazard bag inside the regulated medical waste box; closed the box; removed the washcloths soiled with fecal material from the shared bathroom; placed them in a red biohazard bag; did not change gloves, did not perform hand hygiene, adjusted a wedge under the resident's feet and the wheelchair headrest; removed the gown, gloves and the mask with eye shield; did not perform hand hygiene; removed the closed box from the resident's room; walked to the emergency eye station room; touched the outside door handle to open the door; touched the inside door handle; removed and discarded the gloves in the trash can under the nurses station desk; and performed hand hygiene. During an interview on 10/23/24 at 10:02 A.M., CNA E said there was another resident that shared the bathroom with Resident #205. During an interview on 10/24/24 at 8:30 A.M., the Assistant Director of Nursing (ADON) said contact precautions for ESBL and MRSA, if in the sputum, would be droplet precautions and should include gown, gloves, mask, and a face shield. Resident #205 couldn't use the same bathroom as another resident. If the room had a shared bathroom, staff should provide a urinal/bed pan and a bedside commode for the resident on isolation precautions. During an interview on 10/24/24 at 8:38 A.M., the Director of Nursing (DON) said MRSA and ESBL precautions were contact precautions for urine and droplet precautions if in the sputum. Staff were to wear PPE of a gown, gloves, and a mask with a face shield when providing care for Resident #205. Resident #205 should not share a bathroom with another resident. The resident should have a bed side commode so not to spread the infections to another room or resident. 7. Observation on 10/23/24 at 9:04 A.M., of the emergency eye wash station room showed: - A large trash barrel with the lid open due to the overflow of trash bags, two full trash bags on top of the lid, and seven trash bags on the floor in front of the overflowing trash barrel; - Three red biohazard trash bags and one regulated medical waste box filled with biohazard material in the corner behind the door sat on the floor; - One empty used regulated medical waste box to left of the sink with the top of the box touching the eye wash station and no identifiers on the box; - One full sharps container turned upside down in the right sink basin and one full sharps container sat on the right side of the sink. During an interview on 10/23/24 at 9:31 A.M., CNA E said he/she saw the red bags out of the boxes and sat on the floor of the emergency eye wash station room so he/she removed the red bag from the box and sat the box aside so staff could use the box again. 8. Observation on 10/23/24 at 9:38 A.M., of the soiled utility room showed: - One full and closed regulated medical waste box under the sink; - One large trash barrel with the lid open due to the overflow of trash bags, one full trash bag on top of the lid, and three full trash bags sat on the floor to the right of the large trash barrel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. Observation on 10/23/24 at 10:10 A.M., showed: - Housekeeper I had gloves on and took a trash barrel full of regular full trash bags to the dumpster with fluids leaking out of them; - Housekeeper I did not remove the gloves, did not perform hand hygiene, returned to the facility, and touched multiple door handles, including the eye washing station door; - Housekeeper I did not remove the gloves, did not perform hand hygiene, took out another trash barrel of full regular trash bags to the dumpster while touching multiple door handles; - Housekeeper I removed the gloves, did not perform hand hygiene, returned to the facility, pushed the trash barrel, and touched multiple door handles, including the washing station closet door. During an interview on 10/23/24 at 9:42 A.M., Housekeeper I said he/she emptied the trash barrels in the soiled utility room into the dumpster. He/She threw the red bags out in a different area than the regular trash. He/She believed it was a safety area. During an interview on 10/24/24 at 2:30 P.M., the Administrator said the red biohazard bags for the medical waste trash boxes stay inside the boxes, staff were to take them out of the residents' rooms to be discarded, and placed in the storage unit that the contracted company picked up the waste from. The red biohazard bags and the medical waste boxes should not be kept in the eye wash station and the soiled utility rooms. 47445 50260