

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265558	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2025
NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	

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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>41787</p> <p>Based on interview and record review, the facility failed to implement their abuse and neglect prevention policies, when they failed to complete criminal background checks (CBC) for five sampled staff (Maintenance J, Registered Nurse (RN) E, RN F, Dietary Aide (DA) H, and Housekeeper I). The facility also failed to complete employee disqualification list (EDL - a list of individual prohibited from working in a long-term care facility in Missouri due to a finding of abuse or neglect) checks for three sampled staff (RN E, RN F, and DA H) and failed to complete the Nurse Aide (NA) Registry check for two sampled staff (RN E and RN F) to ensure the staff did not have a Federal Indicator (a marker given to a potential employee who has committed abuse, neglect, or misappropriation of property against residents) prohibiting them from working in a certified facility. Ten employee records were sampled of staff hired since the last survey. The facility census was 59.</p> <p>Review of the facility policy titled Screening - Applicant, Employee, Volunteer and Vendor, dated 05/14/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The policy sets forth the procedure by which the facility will conduct pre-employment, employee, vendor, and volunteer screens;</li> <li>-The Human Resources Department (HR) will conduct pre-employment screens on applicants to determine whether the applicant has committed a disqualifying crime, is an excluded provider of any Federal or State healthcare programs, is eligible to work in the United States, and, if applicable, is duly licensed or certified to perform the duties of the position for which they applied;</li> <li>-Applicant shall complete a request for criminal records check and request for consent to employee disqualification check form;</li> <li>-Prior to hire, HR will conduct a CBC through Missouri Highway Patrol's automated criminal history site. A copy of the results must be printed with the original initialed and dated by the person who conducted the check. If the check is made through the Family Care Safety Registry (FCSR - a Missouri database that can use for various background checks) showing that the applicant is registered and a no finding letter is received and printed, that will satisfy the Missouri Criminal background check requirement and no check needs to be done with the Missouri Highway Patrol;</li> <li>-Prior to hire, HR will conduct Federal Exclusion Lists check:</li> </ul> <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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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Prior to hire, HR will conduct Office of Inspector General (OIG) Exclusion List check. Staff will insert the applicants name in the database. If the result indicates no match, print the results, initial and date, and place in the employee file. If the result indicates that the applicant is excluded, they cannot be hired;</p> <p>-Prior to hire, HR will conduct a FCSR check. Staff will log in to the Missouri Department of Health and Senior Services (DHSS) website FCSR section. This section will check the sex offender, EDL and other Missouri databases automatically;</p> <p>-Prior to hire, HR will conduct Missouri EDL check. This must be checked for every applicant. The results must be printed with the original initialed and dated by the person who conducted the check;</p> <p>-Prior to hire, HR will conduct the CNA Registry check. This must be checked for all applicants regardless of the position for which they are applying. The results must be printed with the original initialed and dated by the person who conducted the check;</p> <p>-The results of each background check must be printed with the original initialed and dated by the person who conducted the check;</p> <p>-This original must be maintained in the applicant's background file.</p> <p>Review of the facility policy titled Abuse and Neglect Policy, dated 06/12/24, showed the following:</p> <p>-The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property;</p> <p>-The purpose is to assure that the facility is doing all that is within its control to prevent occurrences;</p> <p>-The facility will screen employees for a history of abuse, neglect, or mistreating residents by attempting to obtain information from previous employers and/or current employers, and checking the appropriate licensing boards and registries;</p> <p>-The facility will not employ individuals who have been convicted of abusing, neglecting, or mistreating individuals;</p> <p>-Potential employees are screened for history of abuse, neglect, or mistreating individuals.</p> <p>1. Review of Maintenance J's personnel record showed the following:</p> <p>-Hire date of 01/27/25;</p> <p>-Start date on the floor of 02/03/25;</p> <p>-The facility staff documented completion/request of a FCSR or CBC check on 02/10/25.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Review of RN E's personnel record showed the following:</p> <ul style="list-style-type: none"> <li>-Hire date of 10/18/24;</li> <li>-Start date on the floor of 10/23/25;</li> <li>-The facility staff documented completion/request of a FCSR or CBC check on 10/31/24;</li> <li>-The facility staff documented completion of an EDL check on 02/25/25;</li> <li>-Facility staff did not document a check of the NA registry.</li> </ul> <p>3. Review of RN F's personnel record showed the following:</p> <ul style="list-style-type: none"> <li>-Hire date of 10/02/24;</li> <li>-Start date on the floor of 10/11/24;</li> <li>-Facility staff documented completion of FCSR, CBC, or EDL checks on 02/25/25;</li> <li>-Facility staff did not document a check of the NA registry.</li> </ul> <p>4. Review of DA H's personnel record showed the following:</p> <ul style="list-style-type: none"> <li>-Hire date of 02/17/25;</li> <li>-Start date on the floor of 02/21/25;</li> <li>-Facility staff documented completion of FCSR, CBC, or EDL checks on 02/25/25.</li> </ul> <p>5. Review of Housekeeper I's personnel record showed the following:</p> <ul style="list-style-type: none"> <li>-Hire date of 08/28/24;</li> <li>-Start date on the floor of 09/06/24;</li> <li>-Facility staff documented completion of FCSR or CBC check on 02/24/25.</li> </ul> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. During an interview on 02/27/25, at 1:15 P.M., the Business Office Manager (BOM) said the date an employee is interviewed and offered a position becomes their date of hire. Once the employee starts the online onboarding process the system will notify him/her when the paperwork has been entered to start the process for CBC, EDL, nurse aide registry, and FCSR checks. Once the background check has been completed the employee can start work. He/she did not complete nurse aide registry on the nurses. She had only been checking the nursing licensure website for the nurse license. When pulling files for the annual survey, he/she found some files that did not have the EDL checks and completed them on 02/25/25. During the criminal background check process if the online database system stated pending, he/she had to go back to the system every couple of days to see if the check had been completed. He/she must have forgotten to go back and print the FCSR, CBC on these employees. It should have been done before they started working with residents.</p> <p>During an interview on 02/27/25, at 2:20 P.M., the Administrator said when a potential employee had been interviewed and offered a position, all background and licensure checks should be completed before starting work with residents. He was not aware some of the checks had not been documented as completed before staff worked with residents.</p> <p>34871</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871</b></p> <p>Based on interview and record review, the facility failed to ensure all residents received care per professional standards of practice, when staff failed to have processes in place to obtain ordered blood tests in a timely fashion for one resident (Resident #17) out of a total sample of 17 residents. The facility census was 59 .</p> <p>Review of the facility's policy titled, Diagnostic Testing Services Policy, dated 06/26/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The facility will provide the appropriate diagnostic services (laboratory and radiology) required to maintain overall health of its residents and in accordance with State and Federal guidelines;</li> <li>-The facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. No diagnostic tests will be performed without specific physician, physician assistant, nurse practitioner or clinical nurse specialist orders in accordance with State law to include scope of practice laws;</li> <li>-Qualified nursing personnel will receive and review the diagnostic test reports and communicate the results to the ordering physician within 24 hours of receipt unless the report results fall outside of clinical reference ranges and require immediate attention at which time the physician will be notified upon receipt;</li> <li>-Documentation of diagnostic tests, the results, and date/time of physician notification will be maintained in the resident's electronic health record;</li> <li>-In instances where diagnostic testing is not available to be performed on-site or the physician has requested that the services be performed at an off-site facility, this facility will work with the resident and their guardian/family to secure appropriate transportation arrangements for such appointments;</li> <li>-All diagnostic test results will be filed in the resident's electronic health record.</li> </ul> <p>Review of Resident #17's face sheet (gives basic profile information) showed the following information:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel and behave clearly), paranoid schizophrenia, hypertension (HTN - high blood pressure) and chronic obstructive pulmonary disease (COPD - a group of lung diseases that cause long-term breathing problems).</li> </ul> <p>Review of the resident's care plan, revised 04/24/24, showed staff to administer medications as ordered. Staff to monitor and document for side effects and effectiveness. (Staff did not care plan related to labs.)</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 01/10/25, showed the resident was cognitively intact.</p> <p>Review of the resident's February 2025 Physician Order Sheet (POS) showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 09/16/24, for divalproex sodium (an anticonvulsant medication) tablet delayed release 500 milligrams (mg), three tablets by mouth at bedtime for mood stabilizer for schizophrenia;</li> <li>-An order, dated 11/05/24, for labs of complete blood count (CBC - a blood test used to look at overall health and find a wide range of conditions), comprehensive metabolic panel (CMP - a blood test that measures the levels in the blood), A1C (blood test that measures the average blood sugar level over the past two to three months), and depakote level (the therapeutic range for valproic acid - related to divalproex sodium) every day shift every, three months starting on the 5th for one day every three months;</li> <li>-An order, dated of 02/05/25, for a lipid panel (a blood test that measures various types of fat and cholesterol in the blood) and a hepatic lab (blood test that measures liver function) one time a day, every 6 months starting on the 5th for day.</li> </ul> <p>Review of the resident's medical record, on 02/25/25, showed staff did not document obtaining or the results of the ordered CBC, CMP, A1C, and depakote level labs ordered on 11/05/24 or the lipid panel and hepatic panel labs ordered 02/05/25. Staff did not document a reason for the delay or physician notification related to the labs not being obtained timely.</p> <p>During an interview on 02/25/25, at 3:38 P.M., Licensed Practical Nurse A said the following:</p> <ul style="list-style-type: none"> <li>-When a nurse received an order from the physician, he/she entered the order into the computer;</li> <li>-Recently the Director of Nursing (DON) entered the lab orders in the computer;</li> <li>-LPN A just had a crash course on entering STAT labs in the computer;</li> <li>-Staff write ordered labs on the 24 hour report or the DON informs him/her of ordered labs;</li> <li>-Staff enter the lab orders in the computer which goes to the lab company;</li> <li>-The lab company comes to the facility on Monday and Thursday;</li> <li>-Staff print off the requisition order and roster and give to the lab representative;</li> <li>-The lab faxed the results to the facility;</li> <li>-The DON reviews and takes care of the lab results and provider notifications;</li> <li>-The DON informs the nurses of any changes to orders based on the lab results and nurses enter the order in the computer;</li> <li>-He/she did not see the 11/05/24 lab results for the resident.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interviews on 02/25/25, at 3:58 P.M. and 4:30 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-The facility had a new physician and they put in their own lab orders;</li> <li>-The providers did not inform her of what lab orders they enter, so she was not able to enter the order in the lab website;</li> <li>-The provider writes an order, the provider can enter the lab order, but should give her a copy to check the computer as often as she can;</li> <li>-She checks the orders daily;</li> <li>-The lab company comes to the facility on Monday and Thursday;</li> <li>-With the previous provider, she had to review the residents' charts everyday to see if there were any lab orders;</li> <li>-She did not have a report to run of new physician orders;</li> <li>-The 02/05/25 lab order for the lipid panel and hepatic panel was not done;</li> <li>-The resident's CBC, CMP, A1C, and depakote level was due on 11/50/24. She did not see the lab results.</li> </ul> <p>During an interview on 02/28/25, at 11:11 A.M., the Administrator said if a resident had an order for labs to be drawn, they should be drawn as ordered.</p> <p>MO00249509</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48534</p> <p>Based on observation, interview, and record review, the facility failed to ensure all residents received care per standards of practice when staff failed to address one resident's (Resident #45) change in condition timely. The resident's baseline was alert and oriented and cognitively intact. He/she experienced a change which resulted in the resident being unable to respond to questions, unable to feed him/herself, unable to lift his his/her own feet, and unable to express his/her own desires/wishes. The staff failed to send the resident out emergently, failed to follow-up with the physician when the physician did not return an office message, and failed to reach out to the medical director regarding the change of condition on the day the changes were observed. The resident was sent out the following day after contact with the Nurse Practitioner and was admitted to the hospital for high potassium and elevated labs. The facility census was 59.</p> <p>Review of the facility's policy titled, Notification of Changes Policy, revised 05/14/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The purpose of the policy was to ensure the facility promptly informed the resident, consulted the resident's physician; and notified, consistent with his or her authority, the resident's representative when there was a change requiring notification;</li> <li>-The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there was a change requiring such notification;</li> <li>-Circumstances requiring notification include significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental or psychosocial status, which may include life-threatening condition or clinical complications;</li> <li>-For competent individuals, the facility must still contact the resident's physician and notify resident's representative, if known;</li> <li>-When a resident is mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident may not be able to notify them personally, especially in the case of sudden illness or accident;</li> <li>-When a resident was incapable of making a decision, the representative would make any decisions that have to be made.</li> </ul> <p>Review of the facility's policy titled, Notifying Clinicians Policy, revised 06/26/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Policy purpose was to ensure the clinicians are properly notified of a resident's change in condition and overall, health and/or mental status;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The clinician shall be notified of changes in conditions, emergent situations, routine diagnostics, and concerns of the resident's overall health status. Examples included altered mental status, poor intake, changes in behaviors, and anything regarding a change in the residents baseline or condition;</p> <p>-All resident health status updates, changes in condition, and deviation from baseline must be reported to the physician;</p> <p>-The nurse will initiate verbal communication with the clinician (i.e. physician, nurse practitioner (NP), etc.) when a condition or incident arises with resident which would warrant an immediate implementation of a change in plan of care to include physician advisement or initiation of physician orders to avoid a delay in treatment that may cause worsening in condition;</p> <p>-If staff are unable to reach the physician, staff shall notify nursing administration and they will assist in contacting a physician if/when needed. Staff to ensure that there is documentation of time, phone number dialed, and to whom staff spoke with when they reached out to the physician's office. Staff to document if staff reached anyone, or the number of attempts made, and if messages were left;</p> <p>-The licensed nurse will notify the resident's physician or the on-call physician for all changes in conditions, incidents and accidents, and emergency responses after hours to ensure the physician is kept informed and to give guidance;</p> <p>-In the event the licensed nurse cannot reach the physician for guidance, the licensed nurse must call the medical director for guidance;</p> <p>-In the event the licensed nurse cannot reach the physician or the medical director, the licensed nurse must call the director of nursing (DON) for further guidance;</p> <p>-If the licensed nurse cannot get a hold of the physician in an event where a resident needs to be sent to the hospital via 911, the nurse will send the resident to the hospital and continue attempts to notify the physician of the situation.</p> <p>1. Review of Resident #45's face sheet (resident's information at a quick glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included urinary tract infection (UTI), chronic kidney disease (damaged kidneys that can no longer filter blood the way they should), and type two diabetes (a chronic condition that affects the way the body processes blood sugar).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/30/25, showed the following:</p> <p>-The resident was cognitively intact;</p> <p>-The resident used a walker for mobility;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The resident had an indwelling catheter (a tube that is inserted into the bladder allowing urine to drain freely).</p> <p>Review of the resident's care plan, revised 03/13/24, showed the following:</p> <p>-The resident was independent with activities of daily living (ADL - dressing, grooming, bathing, eating, and toileting) and walked with a rolling walker;</p> <p>-Monitor for and document regarding signs and symptoms of UTI including deepening of urine color, altered mental status, change in behavior, and change in eating patterns.</p> <p>Review of the resident's February 2025 Physician Order Summary Report showed the following:</p> <p>-An order, dated 9/23/24, for weekly comprehensive metabolic panel (CMP - a routine blood test that measures various substances in the body to assess overall health and detect potential medical conditions) and complete blood count (CBC - a common blood test that measures various components of the blood to assess overall health and detect potential medical conditions) with differential, one time every Monday;</p> <p>-An order, dated 02/08/25, to send resident to local emergency department for evaluation and treatment if indicated.</p> <p>During an interview on 02/23/25, at 5:31 P.M., the resident said the following:</p> <p>-He/she was on antibiotics for pneumonia and a UTI;</p> <p>-He/she had spent seven days in the hospital;</p> <p>-He/she wore oxygen as needed prior to the recent hospital admission;</p> <p>-He/she had been wearing oxygen continuously since returning from hospital stay.</p> <p>Review of resident's progress note dated 02/23/25, at 11:45 P.M., showed Registered Nurse (RN) E documented the resident was disoriented. The disorientation was new. The resident was coherent, speech was clear, and the resident was able to make him/herself understood. Staff did not document physician notification of the change in condition.</p> <p>Observation on 02/24/25, at 12:05 P.M., of the resident showed the following:</p> <p>-The resident was sitting in his/her recliner, holding the lunch tray of food near his/her left shoulder with one hand;</p> <p>-A plastic cup containing a red liquid had spilled on the tray, ran onto the resident, and ran to the floor below the recliner;</p> <p>-A coffee mug with a lid that contained a liquid sat on the foot stool of the recliner;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The resident's right leg was hanging off the foot stool. The resident's left leg was on foot stool;</p> <p>-The resident tried to sit up in the recliner, but was unable to do so;</p> <p>-The resident was not alert or oriented and kept dozing off;</p> <p>-The resident's nasal cannula was resting on the resident's cheek near his/her right eye;</p> <p>-The resident used his/her right hand to lift his/her right leg onto foot stool. After doing this, the resident's left leg fell off stool;</p> <p>-The resident's lunch tray now sat on the resident's left thigh;</p> <p>-The resident had his/her eyes closed and used his/her fingers to pick up coleslaw off the plate;</p> <p>-The resident attempted to put the coleslaw in his/her mouth. It fell out of his/her hand and on to his/her shirt;</p> <p>-The resident then picked up the black napkin, which was wet from the red liquid that had spilt, off the lunch tray. The resident put the napkin up to his/her mouth and attempted to take a bite.</p> <p>Observation on 02/24/25, at 12:29 P.M., of the resident's room showed the following:</p> <p>-The resident's roommate (Resident #6) entered the room, looked at the resident, and then entered the restroom;</p> <p>-Resident #6 pushed the call light after entering the restroom;</p> <p>-Certified Nursing Assistant (CNA) P entered the residents' room to address the call light;</p> <p>-Resident #6 told CNA P that he/she pushed the call light for Resident #45;</p> <p>-CNA P took the resident's tray and told the resident he/she would be back to help clean up the resident;</p> <p>-The resident had his/her eyes closed and was not responsive to CNA P;</p> <p>-Certified Medication Tech (CMT) D entered the resident's room at 12:31 P.M. The resident opened his/her mouth when prompted by the CMT and the CMT poured the pills out of the cup into the resident's mouth. The resident then took a drink of water, which the CMT held;</p> <p>-The resident had his/her eyes closed and was not otherwise responsive to CMT D;</p> <p>-No staff attempted to adjust the resident's nasal cannula during this time;</p> <p>-CNA P returned to the resident's room and cleaned up the floor. CNA M entered the room to assist CNA P with cleaning the resident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation on 02/24/25, at 3:17 P.M., of the resident showed the following:</p> <ul style="list-style-type: none"> <li>-The resident sat in a wheelchair, with his/her feet on the floor with no foot pedals on the wheelchair;</li> <li>-CNA M pulled the resident in his/her wheelchair behind CNA M with the resident dragging his/her feet;</li> <li>-The resident had his/her eyes closed and appeared lethargic;</li> <li>-The resident was returning from a shower.</li> </ul> <p>Observation on 02/24/25, at 3:34 P.M., of the resident showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was slurring his/her words when trying to answer questions;</li> <li>-The resident appeared unable to keep his/her eyes open and unable to make eye contact.</li> </ul> <p>Review of resident's progress note dated 02/24/25, at 4:13 P.M., showed the DON documented the following as a late entry:</p> <ul style="list-style-type: none"> <li>-The resident had been noted to have increased weakness off and on all day;</li> <li>-The resident was alert and oriented times 3 and able to carry on a conversation with staff;</li> <li>-The resident had decreased urinary output noted and urine was amber in color;</li> <li>-Therapy reported to the DON the resident had been refusing therapy since returning from the hospital;</li> <li>-The resident had not been eating as much when meals were taken to his/her room. Staff were to take the resident to the dining room for meals to ensure the resident was assisted with meals;</li> <li>-The facility physician notified and nursing staff will continue to monitor resident every shift.</li> <li>-The DON did not document when or how the physician was notified and if the physician gave direction regarding care.</li> <li>-The DON did not document a full assessment of the resident's condition.</li> </ul> <p>Observation on 02/24/25, at 5:01 P.M., of the resident showed the following:</p> <ul style="list-style-type: none"> <li>-The resident sat in his/her recliner with the foot stool of the recliner partially up;</li> <li>-The resident's legs were hanging off to the sides of the foot stool;</li> <li>-The resident's dinner tray was sitting on his/her lap;</li> </ul> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The residents oxygen (O2) saturation was not going above 78 percent (normal O2 saturation is 95% -100%);</p> <p>-The resident had weekly labs drawn on 02/24/25, at 5:37 A.M., and the results showed the resident's potassium was high at 6.3 mmol/L;</p> <p>-The DON had not been available at that time for the LPN to give report to;</p> <p>-The resident would refuse to go to the hospital until his/her condition had declined tremendously;</p> <p>-LPN A felt the resident was unable to make decisions due to his/her current condition and needed to be sent out to the hospital;</p> <p>-LPN A was told he/she was not to call the physician regarding residents;</p> <p>-LPN A was to call the DON regarding a resident's change of condition. The DON would contact the physician and then tell the LPN what to do next.</p> <p>During an interview on 02/25/25, at 9:32 A.M., CNA L said he/she assisted the resident with eating breakfast. The resident required prompting to eat. The resident was not alert.</p> <p>During interviews on 02/25/25, at 10:45 A.M., and 02/28/25, at 9:55 A.M., the resident's family member said the following:</p> <p>-The last couple of weeks the resident had gone between alert/oriented and lethargic/disoriented;</p> <p>-The resident refused to go to the local hospital at times, because of a prior experience;</p> <p>-The family member was working and unable to transport the resident to a different hospital;</p> <p>-The family member would have preferred the resident to be sent out to the hospital yesterday 02/24/25;</p> <p>-If the staff were unable to contact the physician, he/she would expect them to keep trying until contact was made;</p> <p>-The family member would expect staff to do what was in the best interest of the resident if the resident was unable to make his/her own decision.</p> <p>Review of the resident's care plan, revised 03/13/24, showed staff did not care plan regarding the resident's hospital preference, or a refusal to go to a local hospital.</p> <p>Review of resident's progress note dated 02/25/25, at 11:43 A.M., showed LPN A documented the following:</p> <p>-The resident was not at his/her baseline when this nurse performed the resident's blood sugar check this morning;</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Resident was able to follow one step commands, but not consistently enough for full neuro exam;</p> <p>-Diagnoses included of hyperkalemia (high potassium level);</p> <p>-The resident's BUN (blood urea nitrogen) level was elevated at 40 milligram per deciliter (mg/dL). (Normal level is between 6 and 20 mg/dl. An elevated BUN can indicate kidney problems or dehydration);</p> <p>-Creatinine (a waste product produced by muscle metabolism) level was 4.17 mg/dL. (Normal range for is .06 to 1.1 mg/dl. An elevated level can indicate kidney problems.);</p> <p>-ALT (alanine aminotransferase) and AST (aspartate aminotransferase) levels were elevated (which can indicate liver cell damage);</p> <p>-Creatinine kinase (an enzyme found primarily in muscle and brain tissues) level was elevated at 746 units per liter (u/l). (Normal range is 30-150 u/l. An elevated level can indicate may indicate muscle injury or disease);</p> <p>-Troponin (a protein complex found in the heart and skeletal muscles) was elevated. (An elevated level can indicate heart damage.);</p> <p>-Blood gases (measurements of the levels of oxygen (O2) and carbon dioxide (CO2) in the blood, as well as the pH (acidity) of the blood) showed respiratory acidosis (a condition where the blood becomes too acidic due to an accumulation of carbon dioxide (CO2)) with a pH of 7.29 (normal pH range is 7.35-7.45);</p> <p>-Elevated CO2 (carbon dioxide) level;</p> <p>-Low O2 (oxygen saturation) at 74% (normal range between 95% to 100%).</p> <p>During an interview on 02/26/25, at 11:08 A.M., CNA O said the resident was fine over the weekend. The resident ate in his/her room and had staff put food trays on his/her lap.</p> <p>During an interview on 02/26/25, at 6:42 P.M., CNA N said the following:</p> <p>-CNA N would notify the charge nurse regarding a resident's change of condition;</p> <p>-The resident was alert and oriented over the weekend and said he/she was feeling much better;</p> <p>-The resident was able to feed herself and carry on a conversation.</p> <p>During an interview on 02/28/25, at 10:01 A.M., CNA P said the following:</p> <p>-On 02/24/25, he/she had gone to check on the resident and found his/her lunch tray on the floor;</p> <p>-CNA P reported to the DON the resident had a change in condition;</p> <p>-CNA P was told the DON would assess the resident;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The resident was not him/herself on 02/24/25. The resident was usually up walking and alert and oriented.</p> <p>During an interview on 02/25/25, at 2:10 P.M., CNA M said the following:</p> <p>-When CNA M noticed a change of condition in a resident he/she reported to the charge nurse or the DON;</p> <p>-The resident's baseline was alert, oriented, talking, and able to walk with walker;</p> <p>-CNA M reported to the DON the resident's change of condition after lunch on 02/24/25;</p> <p>-The DON told CNA M to give the resident a shower to see if that would wake him/her up;</p> <p>-The resident was not alert during the shower and kept falling forward in the shower chair;</p> <p>-The DON helped CNA M give the resident the shower and was aware of the resident's condition;</p> <p>-The resident was slurring his/her speech and was unable to answer questions.</p> <p>During an interview on 02/25/25, at 2:24 P.M., CNA L said the following:</p> <p>-The resident was very independent, able to walk, alert and oriented and able to answer questions;</p> <p>-The resident came back from the hospital last week and was able to answer questions and feed him/herself;</p> <p>-The resident had been lethargic and unable to answer questions yesterday (02/24/25) and today (02/25/25);</p> <p>-On 02/24/25, CNA L took the resident his/her dinner and sat it on his/her lap;</p> <p>-After CNA L delivered the resident's dinner tray on 02/24/25. He/she was told to keep an eye on the resident by the DON;</p> <p>-CNA L returned to the resident's room on 02/24/25 and the resident's dinner tray was on the floor;</p> <p>-On 02/24/25, CNA L helped transfer the resident to his/her wheelchair. The resident was lethargic and slurring his/her speech;</p> <p>-After the resident was transferred to his/her wheelchair on 02/24/25, the resident was taken to the dining room and staff had to assist the resident with eating;</p> <p>-CNA L reported to the DON staff had to assist the resident with eating.</p> <p>During an interview on 02/25/25, at 3:50 P.M., LPN C said the following:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The aides reported changes of condition to the LPN and the LPN would assess the resident. If the resident was not baseline, the LPN would have the registered nurse (RN) assess the resident then contact the DON;</p> <p>-The DON would contact the physician and the resident's next of kin;</p> <p>-The resident's baseline included the resident walking around, going outside, sitting on the porch, talking, and being very coherent;</p> <p>-On 02/24/25, the resident's stomach was swollen and he/she had slurred speech;</p> <p>-The resident did not get insulin on 02/24/25 because the resident's blood sugar was too low for insulin administration. The resident had not eaten breakfast;</p> <p>-On 02/24/25, the resident dumped his/her lunch and dinner tray and ate very little with staff assistance;</p> <p>-LPN C reported to the DON his/her concern for the resident as his/her condition worsened in the afternoon;</p> <p>-On 02/25/25, LPN A asked LPN C to assess the resident. The resident's speech was worse, his/her stomach was more swollen, and his/her cheeks were swollen;</p> <p>-LPN C reported his/her concerns to the DON again. The DON assessed the resident and convinced the resident to go to the hospital;</p> <p>-The resident was his/her own person;</p> <p>-LPN C said the resident's mental status was altered and he/she felt the resident was not able to make his/her own decisions and should have been sent out to the hospital sooner.</p> <p>Review of resident's progress note dated 02/25/25, at 1:05 P.M., showed the DON documented the following:</p> <p>-This nurse was alerted by LPN A the resident was not at baseline;</p> <p>-The day prior, the resident noted to have increased weakness and sleeping more than usual;</p> <p>-When awake the resident was able to have a conversation and was alert and oriented times three;</p> <p>-The resident was still on antibiotics for a UTI and pneumonia from a previous hospital stay;</p> <p>-The resident was his/her own responsible person;</p> <p>-The DON asked the resident after his/her shower on 02/24/25 if he/she wanted to go to the hospital and the resident said he/she did not want to go to the hospital. The DON did not document why or how the resident relayed this information;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-The DON assessed the resident this morning and resident was not able to recall what facility he/she was at or the DON's name;</p> <p>-The resident was asked again about going to the hospital and the resident agreed;</p> <p>-The NP was contacted and orders were given to send the resident to the hospital via EMS.</p> <p>During interviews on 02/26/25, at 1:23 P.M., 02/28/25, at 10:06 A.M., and 02/28/25, at 10:54 A.M., the DON said the following:</p> <p>-Facility staff would notify the DON regarding residents who had a change of condition;</p> <p>-The DON would then contact the physician regarding the resident's change in condition;</p> <p>-The protocol for contacting the physician was to call the number provided by the physician;</p> <p>-The resident's baseline included the resident walking with assistance of a walker, being alert and oriented, and talking;</p> <p>-The resident refused to be sent out to the local hospital at times due to a bad past experience;</p> <p>-The resident's family member would take the resident to a hospital in a neighboring town when possible;</p> <p>-On 02/24/25, the DON checked on the resident during lunch time. The DON did not talk to the resident and was not sure if the resident ate his/her lunch;</p> <p>-The DON and CNA M gave the resident a shower. The resident was extremely weak and the color of his/her urine was dark;</p> <p>-The resident's condition improved after the shower, but only for a brief period;</p> <p>-The resident became lethargic again;</p> <p>-The resident dropped his/her dinner tray on the floor. The DON had staff move the resident to the dining room and assist the resident with eating;</p> <p>-On 02/25/25, LPN A reported to the DON the resident had a change of condition. The resident was not oriented to self or place;</p> <p>-No staff expressed concerns to the DON on 02/24/25 regarding the resident's condition and being sent out;</p> <p>-The DON had called the facility's physician's office the afternoon of 02/24/25 to report the resident's change in condition and left a message regarding the resident's change in condition. The DON did not hear back from the physician nor attempt to try to contact the physician or nurse practitioner again that day;</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-On 02/25/25, the DON made contact with the NP regarding the resident's change of condition;</p> <p>-The DON was advised by the NP to send the resident out to the local hospital;</p> <p>-The resident had an altered mental status;</p> <p>-The DON did not know if there was a policy regarding contacting the physician and what to do if no return call were received from the physician;</p> <p>-If a resident were their own person and had an change in mental status she would contact the resident's family;</p> <p>-If the DON could not get a hold of the physician, after multiple tries, she would send the resident out, call the physician again and let them know the resident was sent to the hospital;</p> <p>-The DON or the charge nurse was responsible for calling the physician when a resident had a change in condition;</p> <p>-All charge nurses have access to the physician's phone numbers.</p> <p>During a phone and text conversation on 02/28/25, at 9:12 A.M., the resident's primary care physician said the following:</p> <p>-The NP said staff did not contact her on Monday (02/24/25), but did contact her on Tuesday (02/25/25) regarding the resident's change in condition;</p> <p>-He did not find any documentation of the facility contacting the provider office on Monday (02/24/25);</p> <p>-He expected the facility staff to contact the provider if the resident slurred his/her words and had a change from his/her baseline. He would had ordered the resident to be sent out for an evaluation.</p> <p>During an interview on 02/28/25, at 9:53 A.M., the Medical Director said the following:</p> <p>-His role for the facility included being available to take calls 24 hours per day;</p> <p>-Staff call him with any questions for medical or psychological issues;</p> <p>-Changes in condition include a change in a resident's temperature, heart rate, mental status, change in functionality, and respiratory rate;</p> <p>-Staff should contact the physician as early as they can if a resident has a change in condition;</p> <p>-Physicians are available after hours and staff have direct contact with the primary care physician;</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	
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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-He is on call 24 hours, seven days a week for all his facilities and staff should call the primary care physician if they cannot get in touch with him;</p> <p>-Staff should had called the primary care physician or the NP for the resident and should have kept calling;</p> <p>-Staff should had kept calling if the resident's condition was different from before.</p> <p>During an interview on 02/28/25, at 10:13 A.M., the Administrator said the following:</p> <p>-When a resident had a change of condition, he expected staff to notify the charge nurse, the charge nurse to assess the resident, and the charge nurse to contact the physician;</p> <p>-If the charge nurse cannot reach the physician, they were to contact the DON and the Administrator;</p> <p>-The charge nurse was to continue to try to reach the physician;</p> <p>-The charge nurse should contact the resident's family regarding the change of condition;</p> <p>-The staff should do what is in the best interest of the resident, if the resident is unable to make their own decisions.</p> <p>MO00249509</p> <p>17193</p> <p>34871</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34871</p> <p>Based on observation, interview, and record review, the facility failed to provide care of pressure ulcers per standards of practice, when staff failed to have processes in place to ensure consistent, accurate, and thorough wound assessments were completed upon discovery and weekly; to complete weekly wound tracking; to complete accurate and timely entries of wound treatments; and to complete wound treatments as ordered for one resident (Resident #22) who had a facility acquired wound that required wound care specialist treatment and was considered for foot amputation. The facility census was 59.</p> <p>Review of the facility's policy titled Wound Treatment Management Policy, reviewed 05/18/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Policy purpose was to promote wound healing of various types of wounds. It was the policy of the facility to provide evidence-based treatments in accordance with current standards of practice and physician orders;</li> <li>-Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change;</li> <li>-In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse;</li> <li>-Treatments will be documented on the Treatment Administration Record (TAR) or in the electronic health record;</li> <li>-The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications included lack of progression towards healing, changes in the characteristics of the wound, and changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.</li> </ul> <p>Review of the facility's policy titled Skin Assessment, last reviewed 06/26/24, showed the following:</p> <ul style="list-style-type: none"> <li>-It was the policy of the facility to perform a full body skin assessment as part of the systematic approach to pressure injury prevention and management. The policy included the procedural guidelines for performing the full body skin assessment;</li> <li>-A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and weekly thereafter. The assessment may also be performed after a change in condition or after any newly identified pressure injury;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Documentation of skin assessment included date and time of the assessment, staff name and position title, observations (skin conditions, how the resident tolerated the procedure, type of wound, wound description (measurements, color, type of tissue in wound bed, drainage, odor, pain)), if the resident refused assessment and why, and other information as indicated or appropriate.</p> <p>1. Review of Resident #22's face sheet (admission data) showed the following:-admitted [DATE];</p> <p>-Diagnoses included schizophrenia (disorder that affects a person's ability to think, feel and behave clearly), chronic kidney disease, and hypertension (high blood pressure).</p> <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 06/06/24 showed the following:</p> <p>-Moderately impaired cognitive skills;</p> <p>-At risk of developing pressure ulcers;</p> <p>-No unhealed pressure ulcers.</p> <p>Review of the resident's progress note dated 07/11/24, at 7:00 P.M., showed a nurse documented the day certified medication aide called the nurse due to the resident being found on the floor. The resident was on his/her left side in a lying position. The resident said he/she ambulated back to his/her room after he/she started feeling dizzy, lost his/her balance, and fell . Staff completed a full assessment to check for physical injuries with no injuries found so far. Staff notified the physician.</p> <p>Review of the resident's physician's progress note, dated 07/16/24, showed the following:</p> <p>-The resident seen for monthly chart review;</p> <p>-The resident had a recent ankle X-ray which showed a nondisplaced avulsion fracture (breaks or splits in the bone) at the tip of the medial malleolus (bony prominence on each side of the ankle);</p> <p>-The resident said he/she had difficulty walking;</p> <p>-There was swelling and tenderness in the medial malleolus of the right ankle;</p> <p>-Diagnosis of closed fracture of malleolus of right ankle;</p> <p>-Orthopedic referral due to nondisplaced avulsion fracture of the tip of the medial malleolus of the right ankle;</p> <p>-Physical and occupational therapy for strengthening conditioning and rehabilitation.</p> <p>(The physician did not document any orders for treatment of the ankle.)</p> <p>Review of the resident's skin/wound note dated 07/19/24, at 10:39 A.M., showed the Director of Nursing (DON) documented the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident fell a week prior and asked to have his/her foot wrapped to relieve pain/pressure. The charge nurse used an elastic bandage to wrap the resident's right ankle. The wrap was left in place for two days before the resident asked the DON to remove it. Upon removal, mild edema (swelling) noted to the resident's entire right foot. The resident developed cellulitis (bacterial infection of the skin and underlying tissues) within two days to the anterior (front) right ankle. A large blister developed in this area as a result of the cellulitis. The area was red, warm, and the blister was filled with fluid.</p> <p>-The DON notified the facility physician and received order to administer doxycycline (an antibiotic) 100 milligrams (mg) for ten days for cellulitis of the right ankle.</p> <p>-The DON gave the resident a soft boot to wear for protection of his/her foot after she applied a protective dressing of iodine (used to disinfect the skin and clean wounds) and dry gauze to protect the blister until it subsided.</p> <p>-The DON educated the resident and staff regarding the proper use of the soft boot and the importance of the resident maintaining good personal hygiene and using the toilet frequently.</p> <p>-Staff will monitor the resident's foot for improvement or decline in status and report directly to the facility physician.</p> <p>(The DON did not document the size of the area.)</p> <p>Review of the resident's medical record showed staff did not document contact with the physician regarding the resident's request for an elastic bandage and did not document an order for the elastic bandage. Staff did not document monitoring the use of the elastic bandage or the skin under the elastic bandage.</p> <p>Review of the resident's skin only evaluation dated 07/19/24, at 11:06 A.M., showed the DON documented the following:</p> <ul style="list-style-type: none"> <li>-Skin warm and dry;</li> <li>-Skin color within normal limits (WNL);</li> <li>-Skin turgor (the skin's elasticity) normal;</li> <li>-Location was right ankle;</li> <li>-Other skin issue description as blister;</li> <li>-Episodic pain;</li> <li>-Right heel discoloration, not painful, and other skin issue description of blister.</li> </ul> <p>(The DON did not document the size of the of area.)</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's skin/wound note dated 07/19/24, at 11:16 A.M., showed the DON documented the following:</p> <ul style="list-style-type: none"> <li>-While she assessed another area on the resident's right foot, she noticed the resident had a small blister to the back of his/her right heel and the entire right heel was no longer blanchable (something that becomes pale or white when pressure is applied). The skin underneath appeared to be dark in color and tender for resident when touched.</li> <li>-The DON notified the facility physician and received orders to apply an iodine soaked gauze dressing and wrap in kerlix (a sterile, cotton bandage to protect wounds) before utilizing a soft boot to the resident's right foot in conjunction with treatment of the blister to the top of the resident's right foot/ankle.</li> <li>-Staff will continue to monitor the resident's foot for further improvement or decline in status and staff will notify the physician of any changes.</li> </ul> <p>(The DON did not document the size of the of areas.)</p> <p>Review of the resident's skin only evaluation dated 07/19/24, at 11:34 A.M., showed the DON documented the following:</p> <ul style="list-style-type: none"> <li>-Skin warm and dry;</li> <li>-Skin color WNL;</li> <li>-Skin turgor normal;</li> <li>-New issue;</li> <li>-Location right ankle with other skin issue description of blister</li> <li>Episodic pain;</li> <li>-Right heel discoloration, not painful and other skin issue description of blister;</li> <li>-New issue of discoloration of right heel that was not painful;</li> <li>-New issue of other skin issue of right heel. Other skin issue description of blister that was not painful.</li> </ul> <p>(The DON did not document the size of the of area.)</p> <p>Review of the resident's progress note, dated as effective on 07/19/24 at 1:07 P.M., and noted to be a late entry, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON documented therapy staff reported the resident had a large blister on the top of his/her right foot/ankle area. The DON assessed the resident and found the blister covered a large area of the anterior aspect of the ankle. The area was where part of the avulsion fracture was located in the X-ray that was completed on the resident the week prior. The resident also had a lot of pain in this area. Underneath the blister, the skin was red and hot and there was a lot of fluid within the blister.</p> <p>-The DON notified the facility physician who gave new orders to drain the blister, cover with an iodine and dry gauze dressing, and start doxycycline 100 mg twice a day and probiotic twice a day for 13 days.</p> <p>-The DON entered all the orders in the computer system and faxed the orders to the pharmacy.</p> <p>-The DON encouraged the resident to wear heel protectors and applied an iodine dressing with a foam heel cup to his/her right heel due to the right heel being discolored (dark purple in color) for skin breakdown prevention.</p> <p>Review of the resident's care plan showed staff did not update the care plan with the newly identified areas to the resident's right heel and right ankle, or related treatments and interventions.</p> <p>Review of the resident's July 2024 Physician Order sheet (POS) showed staff did not transcribe the order to implement or monitor the use of a foam heel cup or the order for doxycycline.</p> <p>Review of the resident's July 2024 TAR showed staff did not transcribe an order to implement or monitor the foam heel cup.</p> <p>Review of the resident's July 2024 Medication Administration Record (MAR) showed an order, dated 07/20/24, for doxycycline hyclate oral tablet 100 mg give one tablet by mouth two times (BID) a day for cellulitis of right ankle for ten days. Staff did not administer the evening dose on 07/20/24.</p> <p>Review of the resident's administration note dated 07/20/24, at 8:27 P.M., showed a nurse documented an order for doxycycline hyclate oral tablet 100 mg, give one tablet by mouth BID for cellulitis of right ankle for ten days. Staff noted the medication was not available.</p> <p>Review of the resident's physician's orders showed an order, dated 07/23/24, for blister to the top right foot/cellulitis. Staff to cleanse with sterile water, cover with iodine soaked gauze, wrap with conforming gauze and secure with non skid socks. Staff to change dressing daily until resolved every day shift. (The order was entered four days after the progress note noted the order was received.)</p> <p>Review of the resident's July 2024 TAR showed an order, dated 07/23/24, for blister to top of right foot from cellulitis. Staff to cleanse with sterile water, cover with iodine soaked gauze, wrap with conforming gauze and secure with non skid sock. Change dressing daily until resolved every day shift. Staff did not document treatments completed 07/19/24 (date ordered) to 07/22/24.</p> <p>Review of the resident's Nurse Practitioner's (NP) progress note, dated 07/23/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident was seen for follow up per staff request. The DON stated the resident had a large blister to the right ankle;</p> <p>-Per notes on 07/19/24, when therapy worked with the resident it was noted the resident had a large blister on top of the right foot and ankle area. Upon further assessment staff found it to be covering a large surface area to the anterior aspect of his/her ankle. The resident's skin was noted to be red and hot surrounding it and there was a lot of fluid within the blister.</p> <p>-Staff notified the physician who gave orders to drain the blister, cover with an iodine dressing and start on cefdinir (used treat bacterial infections) 300 mg two times a day for seven days.</p> <p>-Staff encouraged the resident to wear heel protectors and float his/her ankles.</p> <p>-Staff report the blister was drained and he/she was waiting for a follow up with orthopedic.</p> <p>-The resident digs his/her heels into his/her bed, but that has improved since he/she wears the heel protectors.</p> <p>-The resident's foot was wrapped and floated at this time. The redness extended down his/her foot slightly from the ankle;</p> <p>-Staff to continue with cefdinir for the duration of the seven days as prescribed;</p> <p>-Staff to continue wound care as directed.</p> <p>Review of the resident's medical record showed staff did not document an order to drain the resident's blister, or the process of draining the blister.</p> <p>Review of the resident's July 2024 POS and July 2024 MAR showed staff did not transcribe the order for cefdinir and did not document administration of the cefdinir.</p> <p>Review of the resident's skin only evaluation dated 07/24/24, at 4:03 P.M., showed the DON documented the following:</p> <p>-Skin warm and dry;</p> <p>-Skin color WNL;</p> <p>-Skin turgor normal;</p> <p>-No external device(s) present;</p> <p>-New issue;</p> <p>-Location of right foot and other skin issue description of blister from cellulitis;</p> <p>-No pain;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Right heel discoloration, not painful, with other skin issue description of blister.</p> <p>(The DON did not document the size of the areas or a full assessment of the areas.)</p> <p>Review of the resident's progress notes dated 07/26/24, at 4:27 P.M., showed the DON documented the resident was sent to the orthopedic appointment today. The x-rays on the resident's right ankle showed no fracture and no surgery reported to be necessary at this time due to the resident developed such a large scab over the area on the right ankle where he/she had a large blister from cellulitis. The orthopedic provider's only concern was for the pain and allowing the skin to heal. Staff to continue the daily wound care that was in place of iodine and dry gauze with kerlix wrap and continue the antibiotic for suspected infection.</p> <p>Review of the resident's orthopedic physician orders, dated 07/26/24, showed to continue daily wound care, antibiotic, and non weight bearing on the resident's right leg.</p> <p>Review of the resident's July 2024 TAR showed the following:</p> <p>-An order, dated 07/23/24, for blister to top of right foot from cellulitis. Staff to cleanse with sterile water, cover with iodine soaked gauze, wrap with conforming gauze and secure with non skid sock. Change dressing daily until resolved every day shift;</p> <p>-On 07/26/24, staff did not document completion of the treatment on the top of the resident's right foot;</p> <p>-On 07/30/24, staff did not document completion of the treatment on the top of the resident's right foot.</p> <p>Review of the resident's care plan, dated 08/05/24 showed the following:</p> <p>-The resident has actual impairment to his/her right foot. A stage IV (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) wound to the top of the right foot and stage II (partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) wound to the right heel;</p> <p>-Resident to avoid scratching and keep hands and body parts from excessive moisture;</p> <p>-Staff to follow facility protocols for treatment of injury;</p> <p>-Staff to monitor for side effects of the antibiotics and over the counter pain medications;</p> <p>-Staff to monitor and document location, size, and treatment of the skin injury;</p> <p>-Staff to report abnormalities, failure to heal, signs and symptoms of infection to the medical director.</p> <p>(Staff did not care plan regarding use of heel protector.)</p> <p>Review of the resident's physician's orders, dated 08/07/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-An order for the stage II pressure wound to the right heel. Staff to cleanse the area with wound cleanser and cover with iodine soaked gauze, protect with dry dressing, and wrap with conforming gauze. Staff to change dressing daily every day shift. Registered Nurse (RN) to complete care;</p> <p>-An order for stage II wound to top of the right foot. Staff to cleanse with sterile water, cover with iodine soaked gauze, wrap with conforming gauze, and secure with non skid sock change. Staff to change dressing daily until resolved every day shift. RN to complete wound care.</p> <p>Review of the resident's August 2024 TAR showed the following:</p> <p>-An order for the stage II pressure wound to the right heel. Staff to cleanse the area with wound cleanser and cover with iodine soaked gauze, protect with dry dressing, and wrap with conforming gauze. Staff to change dressing daily every day shift. RN to complete care;</p> <p>-An order for stage II wound to top of the right foot. Staff to cleanse with sterile water, cover with iodine soaked gauze, wrap with conforming gauze, and secure with non skid sock change. Staff to change dressing daily until resolved every day shift. RN to complete wound care.</p> <p>-On 08/08/24, 08/09/24, 08/10/24, and 08/11/24, staff did not document treatment completed as ordered to the resident's right heel and top of the resident's right foot.</p> <p>Review of the resident's physician's progress note, dated 08/12/24, showed the following:</p> <p>-Monthly rounds;</p> <p>-No reported redness or swelling. His/her right lower extremity was wrapped and in a heel protector;</p> <p>-The resident or nursing staff did not have any complaints or issues;</p> <p>-No rashes or skin breakdown;</p> <p>-Continue all current medications and treatment plan.</p> <p>(The physician did not address the two pressure wounds on the resident's right foot.)</p> <p>Review of the resident's August 2024 TAR showed on 08/14/24 and 08/15/24, staff did not document treatment completed as order to the resident's right heel and top of the resident's right foot.</p> <p>Review of the resident's skin/wound note, dated as effective on 08/16/24 at 3:55 P.M., and noted to be a late entry, showed the following:</p> <p>-The DON completed the resident's wound care. The rest of the large scab covering the resident's anterior right ankle came away from the wound. Underneath the scab was yellow slough (dead tissue usually yellow or cream in color) covering the entire wound bed. A moderate amount of purulent (pertaining to pus) drainage present with no odor at this time. Edges of wound remained intact.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON completed wound care to the right heel. The slough covering remained dark in color and yellow around the edges. As the slough peeled away, underneath there was granulation tissue (a sign of healing) present at the top. The edges were intact with a scant amount of bleeding noted. The resident verbalized no pain or discomfort at this time.</p> <p>(The DON did not document measurements of the wounds.)</p> <p>Review of the resident's August 2024 TAR showed on 08/17/24 and 08/18/24, staff did not document treatment completed as ordered on the resident's right heel and top of the resident's right foot.</p> <p>Review of the resident's skin/wound note, dated as effective on 08/19/24 at 10:14 A.M., and noted to be a late entry, showed the following:</p> <p>-The DON completed wound care to the right anterior ankle and right heel.</p> <p>-No change noted to the dark colored slough that continued to peel from the right heel. It also had yellow slough peeling from the edges still. The top of the wound continued to have granulation tissue present. No odor present. Purulent drainage noted in moderate amount.</p> <p>(The DON did not document measurements of the resident's wound on the resident's right foot.)</p> <p>Review of the resident's skin/wound note, dated as effective on 08/19/24 at 5:30 P.M., and noted to be a late entry, showed the following:</p> <p>-DON completed wound care. (Location of wound not specified.)</p> <p>-Edges remain intact. The entire wound bed was covered with yellow-green slough throughout with 25% granulation tissue present with a scant amount of blood noted. Tendon noted to be present in middle of the wound. Odor present and moderate purulent drainage noted.</p> <p>-DON immediately notified the facility physician and waited for new orders.</p> <p>(The DON did not document measurements of the resident's wounds on the resident's right foot)</p> <p>Review of the resident's skin/wound note dated 08/20/24, at 3:00 P.M., showed the DON documented the following:</p> <p>-The DON completed wound care to the resident's anterior right ankle. The wound was previously staged as a stage II and changed to a stage IV due to the tendon now exposed. The slough was debrided and new granulation tissue was visualized. The tendon had become more prevalent in the center and off to the lateral side of the wound. Granulation tissue made up approximately 45% of the wound bed at this time. The center continues to have a dark yellow-green slough. The edges of the wound were intact with moderate bleeding noted during wound care. A moderate amount of purulent drainage and odor remain.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON completed wound care to the resident's right heel. The dark colored slough continued to peel off slowly with yellow slough remaining underneath and along the edges. Granulation tissue was present at the top of the wound and along the sides and made up approximately 25% of the wound bed. Edges surrounding the wound remained intact. Scant amount of bleeding noted with moderate amount of drainage and no odor.</p> <p>The DON to measure and take pictures of both wounds on 08/21/24 during scheduled wound care and place within the chart.</p> <p>-The physician ordered doxycycline 100 mg BID for ten days for infection of the right ankle wound and a consult scheduled with the wound care clinic on 08/29/24.</p> <p>(The DON did not document measurements of the resident's wound on the resident's right foot)</p> <p>Review of the resident's September 2024 Physician Order Sheet (POS) showed an order for the following:</p> <p>-An order, dated of 08/20/24, for acidophilus (used as a probiotic to promote the growth of good bacteria in the body) oral tablet for staff to give one tablet by mouth (PO) two times a day for antibiotic use for 13 days;</p> <p>-Staff transcribed the order for doxycycline to the POS.</p> <p>Review of the resident's progress note dated 08/20/24, at 11:16 P.M., showed the DON documented an order received from the physician to start the resident on doxycycline 100 mg BID for ten days and probiotic tablet PO BID for 13 days for wound infection. The DON entered the orders and faxed to the pharmacy. The nurse practitioner saw the resident during medical rounds. The facility staff made contact with the local wound care clinic and the resident had an appointment set for a consult in their office on 08/29/24.</p> <p>Review of the resident's skin/wound note, dated as effective on 08/21/24, at 9:55 P.M., and noted to be a late entry, showed the following:</p> <p>-The DON completed wound care per instructions to the resident's right anterior ankle. The edges remained intact and an odor remains present at this time with moderate amount of drainage. Yellow slough covered the center of the wound in approximately 50% surrounding the tendons that are visible. Granulation tissue remains visible to 35% of wound with moderate amount of bleeding noted during cleaning of the wound.</p> <p>-The DON completed wound care to the right heel. The edges remain intact with no odor present. A moderate amount of drainage noted. Dark colored and yellow slough continues to peel off slowly at this time covering 40% of the wound. 25% of granulation tissue noted to be visible at this time.</p> <p>(The DON did not document measurements of the resident's wound on the resident's right foot)</p> <p>Review of the resident's physician's orders, dated 08/21/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-An order for stage II pressure wound to the right heel. Staff to cleanse with sterile water, cover wound bed with silver wound dressing and dry gauze, wrap with conforming gauze and secure with non skid socks. Staff to change dressing daily until resolved every day shift. RN to complete wound care;</p> <p>-An order for stage IV wound to top of the right foot. Staff to cleanse with sterile water, cover wound bed with silver wound dressing and dry gauze, wrap with conforming gauze and secure with non skid sock change dressing daily until resolved every day shift. RN to complete wound care.</p> <p>Review of the resident's August 2024 MAR showed the following:</p> <p>-An order, dated 08/21/24, for doxycycline hyclate (antibiotic) oral tablet 100 mg give one tablet PO BID a day for infected wound to right ankle for 10 days;</p> <p>-An order, dated of 08/21/24, for acidophilus (probiotic) oral tablet for staff to give one tablet PO two times a day for antibiotic use for 13 days;</p> <p>-On 08/23/24, staff did not document administration of the antibiotic or probiotic.</p> <p>-Staff did not document administration of the doxycycline on 08/23/24 for the AM and PM doses.</p> <p>Review of the resident's August 2024 TAR showed the following:</p> <p>-An order, dated of 08/21/24, for staff to cleanse with sterile water, cover wound bed with silver wound dressing and dry gauze, wrap with conforming gauze and secure with non skid socks. change dressing daily until resolved every day shift for stage two pressure wound to right heel. RN to complete wound care;</p> <p>-An order, dated 08/21/24, for staff to cleanse with sterile water, cover wound bed with silver wound dressing and dry gauze, wrap with conforming gauze and secure with non skid sock change dressing daily until resolved every day shift for stage IV wound to top of right foot. RN to complete wound care.</p> <p>Review of the resident's skin/wound notes, dated as effective on the dates below and noted as late entries, showed the DON completed wound care to the right anterior ankle. The edges remained intact and an odor remains present at this time with a moderate amount of drainage. Yellow slough covered the center of the wound in approximately 50% of surrounding the tendons that are visible. Granulation tissue remained visible to 35% of wound with moderate amount of bleeding noted during cleaning of the wound. The DON completed wound care to the right heel. The edges remain intact and no odor present and moderate amount of drainage noted. Dark colored and yellow slough continues to peel off slowly at this time covering 40% of the wound 25% of granulation tissue noted to be visible at this time.</p> <p>(The DON did not document measurements of the resident's wound on the resident's right foot)</p> <p>-Effective 08/22/24, at 11:12 A.M.;</p> <p>-Effective 08/23/24, at 10:03 A.M.;</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Effective 08/24/24, at 12:15 P.M.</p> <p>Review of the resident's skin/wound note, dated as effective on 08/25/24, at 9:33 A.M., and noted to be a late entry, showed the following:</p> <p>-The DON completed wound care to the right anterior ankle. Edges remain intact and an odor remains present at this time with moderate amount of drainage. Yellow slough covers the center of the wound in approximately 55% surrounding the tendons that are visible. Granulation tissue remains visible to 35% of wound with moderate amount of bleeding noted during cleaning of the wound.</p> <p>-The DON completed wound care to the right heel. Edges remain intact and no odor present and moderate amount of drainage noted. Dark colored and yellow slough continues to peel off slowly at this time covering 60% of the wound 40% of granulation tissue noted to be visible at this time.</p> <p>(The DON did not document measurements of the resident's wound on the resident's right foot)</p> <p>Review of the resident's skin/wound notes, dated as effective on the dates below and noted as late entries, showed the DON completed wound care to the right anterior ankle. The edges remained intact and an odor remains present at this time with a moderate amount of drainage. Yellow slough covered the center of the wound in approximately 50% of surrounding the tendons that are visible. Granulation tissue remained visible to 35% of wound with moderate amount of bleeding noted during cleaning of the wound. The DON completed wound care to the right heel. The edges remain intact and no odor present and moderate amount of drainage noted. Dark colored and yellow slough continues to peel off slowly at this time covering 40% of the wound 25% of granulation tissue noted to be visible at this time.</p> <p>(The DON did not document measurements of the resident's wound on the resident's right foot):</p> <p>-Effective 08/26/24, at 4:30 P.M.;</p> <p>-Effective 08/27/24, at 1:46 P.M.</p> <p>Review of the resident's physician's progress note, dated 08/27/24, showed the following:</p> <p>-The resident visits the wound clinic in the next few days. The nursing staff state he/she urinates on his/her wound on his/her right foot. Apparently he/she had a stage IV wound on top of his/her foot and a stage II wound on the bottom of his/her foot. Nursing staff state that it has a putrid odor. He/she had a significant wound that was presently dressed on the right foot with a putrid smell coming from the area;</p> <p>-Order for rocephin one gram IM (intramuscularly) daily for five days;</p> <p>-Resident to see the wound care specialist in the next one to two days;</p> <p>-Continue all other current medications and treatment plan.</p> <p>Review of the resident's skin/wound note, dated as effective on 08/28/24, at 2:33 P.M., and noted to be a late entry, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The DON completed wound care to the right anterior ankle. Edges remain intact and an odor remains present at this time with moderate amount of drainage continued to be present. Dark yellow slough covers the center of the wound in approximately 50% surrounding the tendons that are visible. Granulation tissue remains visible to 35% of wound with moderate amount of bleeding noted during cleaning of the wound.</p> <p>-The DON completed wound care to the right heel. Edges remain intact and no odor present and moderate amount of drainage noted. Dark colored and yellow slough continues to peel off slowly at this time covering 40% of the wound 25% of granulation tissue noted to be visible at this time.</p> <p>(The DON did not document measurements of the wounds on the right foot.)</p> <p>Review of the resident's skin/wound note, dated as effective on 08/29/24, at 8:51 P.M., and noted to be a late entry, showed the following:</p> <p>-The DON cleaned the resident's wounds to both the right anterior ankle and right heel as per treatment order. She applied a simple dry protective dressing Xeroform (non-adherent primary dressing that maintains a moist wound environment) to both areas before the resident left to to to his/her appointment with the wound care clinic.</p> <p>-DON received a phone call from the wound doctor while the resident was at the appointment with concerns regarding the resident's right anterior ankle wound and the tendons showing. The wound doctor stated he/she felt the resident's foot may need to be amputated at this point with how quickly the wound declined and the resident's cardiologic issues. The wound doctor requested pictures of the start to present of the fast progression of the wound and the DON provided the pictures to him/her.</p> <p>Review of the resident's wound clinic doctor's consultation dated 08/29/24, at 10:42 A.M., showed the following:</p> <p>-The resident had a fall with a right ankle sprain a couple days after his/her admission to the facility with a little avulsion fracture of his/her medial malleolus. The resident had an elastic wrap on it for a couple days. The resident had blistering and was treated for cellulitis;</p> <p>-Facility staff told him/her a scab appeared and when the scab came off, all the skin came off with it and the resident had exposed tendon on the anterior ankle and eschar (non viable tissue due to reduced blood supply) on the right heel with exposure of the distal or most inferior Achilles (the thick, fibrous cord that connects the calf muscles to the heel bone) tendon and the calcaneus (heel bone);</p> <p>-Staff placed Xeroform gauze on the wound at this time;</p> <p>-There is a large ulcer</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>34871</p> <p>Based on interview and record review, the facility failed to ensure consistent and sufficient Registered Nurse (RN) and Director of Nursing (DON) hours to allow the DON to complete the duties of DON when the DON frequently had to work as the charge nurse. The facility census was 59.</p> <p>Review of the facility's job description titled Director of Nursing, undated, showed the following:</p> <ul style="list-style-type: none"> <li>-The DON provides leadership and direction for overall medical care to provide quality patient care in accordance with all laws, regulations, and the management company;</li> <li>-DON duties were to oversee the nursing staff and overall nursing operations of the healthcare facility;</li> <li>-Duties included evaluating and directing all nursing employees, establishing goals for the nursing department, and creating and enforcing compliant healthcare policies;</li> <li>-Duties included overseeing key areas including financial operations, human resources, customer service, business development, and clinical and nursing administrative operations;</li> <li>-The DON will coordinate and provide leadership to each clinical, managerial, and supplemental staff and ensure that they work together;</li> <li>-The DON implemented policies pertaining to patient care, care giving and support staff, financial control, public relations, and maintenance of physical plant through consultation with the facility management team;</li> <li>-The DON managed budget to meet facility needs and division goals in accordance with all applicable laws, regulations, and the management company standards.</li> </ul> <p>Review of the facility's staffing schedule showed the DON worked as the charge nurse on the following dates:</p> <ul style="list-style-type: none"> <li>-On 02/15/25 day shift (6:00 A.M. to 6:00 P.M.);</li> <li>-On 02/16/25 day shift (6:00 A.M. to 6:00 P.M.);</li> <li>-On 02/19/25 night shift (6:00 P.M. to 6:00 A.M.);</li> <li>-On 02/20/25 night shift (6:00 P.M. to 6:00 A.M.).</li> </ul> <p>During interviews on 02/24/25, at 9:32 A.M., 02/26/25, at 11:55 A.M., 02/27/25, at 12:05 P.M. and 2:50 P.M., and on 02/28/25 at 12:35 P.M. the DON said the following:</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-DON duties included monitoring wounds, maintaining everything related to nursing, completing the nursing schedule, overseeing the nursing program, monitoring with the pharmacy, monitoring the antibiotic stewardship program, and she was also the infection preventionist;</p> <p>-She monitors the wounds and used to have an Assistant Director of Nursing (ADON) to help, but the facility had been down several nurses for awhile;</p> <p>-She completed wound care on everyone, because at one time the wound care did not get it done. She came to the facility seven days a week. That is a big part of why the documentation has not been completed;</p> <p>-She used to go through the residents' charts for the gradual dose reductions and emailed lists with residents' names to the physician;</p> <p>-She used to have an ADON who assisted with the Infection Control. She had not kept up with the antibiotic review;</p> <p>-She did not complete competency evaluation with nursing aides;</p> <p>-She worked as a charge nurse at times which made it difficult to get her duties completed.</p> <p>During an interview on 02/28/25, at 3:48 P.M., the Administrator said he expected the DON duties to be completed and he was aware she was working as a charge nurse at times.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17193</p> <p>Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of each resident when staff failed to obtain and administer medications as ordered for one resident (Resident #41). The facility census was 59.</p> <p>Review showed the facility did not provide a policy regarding pharmacy services or obtaining medications for administration.</p> <p>Review of Resident #41's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included chronic kidney disease stage 5 (damage to kidneys and less likely to filter waste and fluid out of the blood).</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/8/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Cognition intact;</li> <li>-Renal (kidney) failure;</li> <li>-On a diuretic medication (a medication that increases the production and excretion of urine by the kidneys).</li> </ul> <p>Review of the resident's current care plan, dated 03/06/24, showed staff to administer medications as ordered.</p> <p>Review of the resident's physician's orders showed an order, dated 03/01/24, for bumetanide (Bumex - medication used to treat edema (swelling caused by fluid trapped in the body's tissues)) oral tablet 1 milligram (mg), give one tablet by mouth two times a day for chronic kidney disease.</p> <p>Review of the resident's February 2025 Medication Administration Record (MAR) showed the following:</p> <ul style="list-style-type: none"> <li>-On 02/23/25, staff did not administer the resident's bumetanide as scheduled at 6:00 A.M. and 4:00 P.M. Staff documented a 9 to that indicated staff did not administer to the resident since the medication was unavailable in the facility;</li> <li>-On 02/24/25, Certified Medication Tech (CMT) D documented a check mark to indicate he/she administered the resident's bumetanide as scheduled at 6:00 A.M. and the 4:00 P.M.;</li> <li>-On 02/25/25, CMT D documented a check mark to indicate he/she administered the resident's bumetanide as scheduled at 6:00 A.M. The CMT document a 9 for the 4:00 P.M. dose.</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/25/25, at 3:50 P.M., CMT D said they were waiting for the resident's bumetanide to come in from the pharmacy for the resident. CMT D was unable to find the resident's bumetanide medication in the medication cart or in the overflow medication cards in the medication room. Usually all medication technicians re-order medications. The CMT said the Director of Nursing (DON) usually took care of medications that did not come in from the pharmacy.</p> <p>Review of the resident's February 2025 MAR showed on 02/26/25 staff documented staff did not administer resident's bumetanide scheduled 6:00 A.M. dose. CMT B documented a 9 on the MAR to indicate the medication was not available in the facility.</p> <p>During an interview on 02/26/25, at 9:58 A.M., CMT B said he/she did not have the resident's bumetanide to give the resident for his/her morning medication. He/she was not sure why it was not there. CMTs were to reorder medications. He/she had not worked since last week.</p> <p>Review of the resident's medical record showed staff did not document steps taken to obtain the medication that was not available or physician notification of the missed doses.</p> <p>During an interview and observation on 02/26/25, at 9:31 A.M., in the medication room showed there were two large dark bags on counter in the medication room. Licensed Practical Nurse (LPN) A said the medication technicians were responsible for putting medications away when delivered from the pharmacy. He/she was not sure why it wasn't done this morning. They never know when the pharmacy delivers medication to the facility. The med techs and nurses were responsible for re-ordering medications. There was a blue colored strip on the medication card when it was time to re-order. They were to pull the sticker with the medication name, dose, and strength etc. and put this on sheet of paper, and when the page was full or by 1:00 P.M. that same day, they were to fax this in to the pharmacy.</p> <p>During interviews on 02/26/25, at 11:52 A.M., and 02/27/25, at 2:25 PM, the DON said the following:</p> <ul style="list-style-type: none"> <li>-If a medication was unavailable during the medication pass, the medication technicians were to leave her a note so she could review it;</li> <li>-She would have talked to their facility pharmacy if the resident's pharmacy did not send the medication;</li> <li>-On the resident's February 2025 MAR the staff documented 9 to indicate they did not administer the bumetanide medication to the resident. She was unaware of staff not administering bumetanide to the resident;</li> <li>-Staff was to leave a list of medications they needed to order before they left that day. Staff were to let her know if she was working that day;</li> <li>-When she reviewed the resident's pharmacy order, the bumetanide medication was ordered on 02/04/25, but documented as too early to refill. If she would have known about this note, she would have gotten the bumetanide medication from their facility pharmacy.</li> </ul> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 02/27/25, at 2:47 PM, the Administrator if a resident's medication was not available for administration he would expect staff to notify the DON and obtain the resident's medication.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17193</p> <p>Based on interview and record review, the facility failed to ensure the physician responded in a timely manner to pharmacist recommendations during the monthly pharmacist review, when the physician did not address the pharmacist recommendation to discontinue one medication not recommended for use in the elderly due to its anticholinergic side effects (causing falls and confusion) for one resident (Resident #12) in a timely manner. The facility census was 59.</p> <p>Review showed the facility did not provide a policy regarding the pharmacy medication review and recommendation process.</p> <p>Review of Resident #12's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses that included cervical disc disorder with myelopathy (problems with the neck's bones, muscles, joints with symptoms of weakness, tingling, pain, and numbness in the neck or arms, and problems with coordination), heart failure, high blood pressure, chronic pain, arthritis, and retention of urine.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/04/25, showed the resident's cognition was intact and resident was always incontinent of urine.</p> <p>Review of the resident's care plan, revised 05/02/24, showed the resident required total assistance by two staff for toileting.</p> <p>Review of the resident's physician's orders showed an order, dated 09/19/24, for oxybutynin chloride (anticholinergic medication used to treat bladder conditions) oral tablet 5 milligrams (mg) to give 10 mg by mouth one time a day for bladder spasms.</p> <p>Review of the resident's Pharmacy Review Note in the Consultant Pharmacist Regimen Review Communication Report, dated 10/18/24, showed the the pharmacist noted the following:</p> <ul style="list-style-type: none"> <li>-Regarding oxybutyninchloride oral tablet 5 mg, give 10 mg by mouth one time a day for bladder spasms. Please assess risk versus benefits and if the resident would benefit from discontinuing the oxybutyninchloride 5 mg daily order and add Gemtesa (treats overactive bladder when have urgent need to urinate) 75 mg daily. Oxybutyninchloride is not recommended in the elderly due to strong anticholinergic side effect profile, which will increase risk for falls and confusion, and increased risk occasional disorientation. Whenever possible, use in the elderly should be avoided. Gemtesa has no anticholinergic properties. Please address in your progress note if the change is clinically contraindicated;</li> <li>-There were spaces for physician to mark agree or disagree. The spaces were not marked.</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	
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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's progress notes, dated 11/20/24, showed a note from the pharmacist for the facility to please follow-up with the pharmacist recommendation from October 2024 and request a response from the physician. Staff to place response in the electronic medical record (EMR).</p> <p>Review of resident's medical record showed staff did not document follow-up regarding the pharmacist recommendation in October 2024 or November 2024.</p> <p>Review of the resident's care plan, updated 12/28/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a fall with no injury;</li> <li>-Staff to monitor/document/report as needed for 72 hours for signs/symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, and agitation.</li> </ul> <p>Review of the resident's progress note, dated 01/17/25, showed the pharmacist reviewed the resident for fall assessment. Due to diagnoses and medications ordered, the resident was at risk for falling. The pharmacist recommended reducing the risk associated with falling by reviewing recommendation for Gemtesa recommendations from 10/18/24.</p> <p>Review of resident's medical record showed staff did not document follow-up regarding the pharmacist recommendation in December 2024, January 2025, or February 2025.</p> <p>During an interview on 02/28/25, at 12:35 P.M., the Director of Nursing said the following:</p> <ul style="list-style-type: none"> <li>-He/she did not remember the resident's Gradual Dose Reduction (GDR) report when she pulled it up on the electronic medical record (EMR);</li> <li>-The process was in the EMR and it showed in the system for the GDRs from the pharmacist. The physicians have access to the EMR too;</li> <li>-Any nurse or the physician was responsible to review them and can send them to the physician. They all have access to the EMR;</li> <li>-She can print this recommendation out and put in a book, but she never knows when the physicians are coming to the facility. The physicians don't have a schedule coming to the facility, and the GDRs recommendations would just sit in a book;</li> <li>-She used to go through the residents' charts for the GDRs and email lists with residents' names to the physicians. The pharmacist will send an email with the recommendations after he/she has looked at the residents' records;</li> <li>-She didn't remember seeing this GDR for the resident, but as of today, their new facility physician's nurse practitioner had addressed the recommendations and had switched the medication to the recommended Gemtesa. She hadn't been able to put this order into the EMR yet.</li> </ul>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17193</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate not greater than 5%, when facility staff crushed extended release tablets for one resident (Resident #23) and when staff did not administer a medication for one resident (Resident #41). This resulted in two errors out of 36 opportunities and medication error rate of 5.56%. The facility census was 59.</p> <p>Review of the facility policy Medication Administration Policy, revised 6/26/24, showed medications that typically should not be crushed included sustained-release or extended-release medications.</p> <p>1. Review of the Drugs.com warnings for Potassium Chloride, updated 02/29/24, showed the following:</p> <ul style="list-style-type: none"> <li>-Do not crush, chew, break, or suck on an extended-release tablet or capsule. Swallow the pill whole.</li> <li>-Breaking or crushing the pill may cause too much of the drug to be released at one time.</li> </ul> <p>Review of Resident #23's face sheet (a brief look at resident information), showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included hypokalemia (low potassium level).</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 01/21/25, showed the resident was cognitively intact and received a diuretic (medication substances that increase urine output by promoting the excretion of water and electrolytes, such as sodium, potassium, and chloride, through the kidneys).</p> <p>Review of the resident's care plan, dated 01/10/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident had a nutritional problem or potential nutritional problem related to diet restrictions, obesity (overweight), and hypokalemia;</li> <li>-Staff to administer medications as ordered and monitor for and document side effects and effectiveness.</li> </ul> <p>Review of the resident's physician's orders showed an order, dated 02/21/25, to give potassium 40 milliequivalent (meq) by mouth one time a day for potassium deficiency.</p> <p>Observation on 02/26/25, at 8:40 A.M., showed Certified Medication Technician (CMT) B crushed all medications including the resident's potassium chloride 20 meq two tablets (a total of 40 meq). She added the crushed medications into a small cup and mixed them with a big spoon of chocolate pudding. CMT B gave the pudding with pills which included the crushed potassium chloride tablets to the resident and encouraged the resident to drink a cup of water.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 02/26/25, at 11:36 A.M., CMT B said he/she did not know where there was a list of medications not to crush.</p> <p>Observation on 02/26/25, at 3:05 P.M., showed CMT B checked the medication cart for the resident's medication potassium chloride which was ER (extended release). He/she said he/she did not know it was an extended release potassium chloride medication and knew they were not to be crushed.</p> <p>During an interview on 02/26/25, at 11:32 A.M., Licensed Practical Nurse (LPN) A said he/she didn't think potassium chloride pills should be crushed. There were effervescent (tablets that dissolve in water) potassium chloride tablets to place in water for residents. LPN A didn't know for sure where there was list of medications not to crush.</p> <p>Observation on 02/27/25, at 1:40 P.M., showed the Director of Nursing (DON) opened the medication cart and found the resident's potassium chloride medication card which read potassium CL ER 20 meq times two daily on label.</p> <p>During interviews on 02/26/25, at 11:52 A.M., and 02/27/25, at 1:40 P.M., the DON said said the following:</p> <ul style="list-style-type: none"> <li>-Staff were not to crush potassium chloride medication before administering to a resident;</li> <li>-This should be a liquid or in a powder form for the resident.</li> </ul> <p>During an interview on 02/27/25, at 2:47 P.M., the Administrator said he would expect staff not to crush potassium chloride if it was not to be crushed.</p> <p>2. Review of Resident #41's face sheet showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included chronic kidney disease stage 5 (damage to kidneys and less likely to filter waste and fluid out of the blood).</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Cognition intact;</li> <li>-Renal (kidney) failure;</li> <li>-On a diuretic medication (a medication that increases the production and excretion of urine by the kidneys).</li> </ul> <p>Review of the resident's care plan, dated 03/06/24, showed staff to administer medication as ordered. Staff to monitor for effectiveness and side effects.</p> <p>Review of the resident's physician's orders showed an order, dated 03/01/24, for bumetanide (used to treat edema (a condition where excess fluid accumulates in the body's tissues, causing swelling) oral tablet 1 mg, give one tablet by mouth two times a day for chronic kidney disease.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 02/25/25, at 3:50 P.M., showed CMT D administered the resident's evening medications. The medications did not include the ordered bumetanide. The CMT said they were waiting for the bumetanide to come in from the pharmacy for the resident.</p> <p>During interviews on 02/26/25, at 11:52 A.M., and 02/27/25, at 2:25 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-If a medication was unavailable during the medication pass, the med techs were to leave her a note so she could review it;</li> <li>-She was unaware of staff not administering the resident's bumetanide.</li> </ul> <p>During interview on 02/27/25, at 2:47 P.M., the Administrator said he would expect staff to notify the DON and obtain the resident's medication for administration.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48534</b></p> <p>Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in a manner to protect food from possible contamination, when staff failed to use effective hair restraints; failed to consistently label and date food; failed to wash hands and equipment appropriately during food prep; failed to ensure food kept in mini refrigerators in resident rooms was not expired or spoiled; and when staff failed to ensure non-food contact surfaces in the kitchen were clean and maintained in good repair. The facility census was 59.</p> <p>1. Review of the facility's policy titled, Dietary - Receiving and Storing Food and Supplies, revised [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Food items will be received and handled in accordance with good sanitary practice;</li> <li>-Food items will be stored, thawed, and prepared in accordance with good sanitary practice;</li> <li>-All products shall be dated upon receipt or when they are prepared. Use date shall be marked on all food containers according to the timetable in the dry, refrigerated, and freezer storage chart found in this section. Leftovers shall be dated according to the leftovers policy;</li> <li>-Fresh meats shall be cooked or frozen within three to four days of purchase depending on the type of meat;</li> <li>-Store items promptly at 0 degrees Fahrenheit (F) or below. Foods shall be stored in their original containers if designed for freezing;</li> <li>-Items should be covered with non-absorbent lid or material;</li> <li>-Date containers (lids may be misplaced);</li> <li>-Label food unless easily identifiable without removing cover.</li> </ul> <p>Review of the facility's policy titled, Dietary Food Preparation, revised [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Place leftover food and/or beverage in seamless containers with tight-fitting lids, zipper bags, or wrapped completed in plastic film. Label and date all containers.</li> </ul> <p>Observations on [DATE], at 3:49 P.M., [DATE], at 8:48 A.M., [DATE], at 12:19 P.M., and [DATE], at 5:19 P.M., of the walk-in refrigerator showed the following:</p> <ul style="list-style-type: none"> <li>-Three 16 ounce bags of non-dairy whipped topping with no date thawed on them. The packages stated good for one year frozen and 14 days thawed;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-A box containing individual packages of turkey bologna, not dated. The box had a label that read keep frozen at 0 or below. No received, thawed, or use by/expire date could be located on the box or individual packaging;</p> <p>-A box, dated ,d+[DATE], containing four boneless pork loins, with no thaw date. The box had a label that read keep refrigerated or frozen. The date ,d+[DATE] was the receive date. No other date could be found on box or individual packaging.</p> <p>Observations on [DATE], at 4:07 P.M., [DATE], at 8:48 A.M., and [DATE], at 12:20 P.M. of the walk-in freezer showed the following:</p> <p>-Three serving bowls that contained orange sherbet. One bowl was covered and dated ,d+[DATE]. Two bowls not covered or dated. The sherbet was dried out on top and looked freezer burnt.</p> <p>Observation on [DATE], at 5:19 P.M., of the walk-in refrigerator showed the following:</p> <p>-A box, dated ,d+[DATE] (received date), with an open date of ,d+[DATE], of Italian sausage. The label read keep frozen. There was no use by/expiration date and the meat was starting to turn brown.</p> <p>During an interview on [DATE], at 2:10 P.M., [NAME] S said the following:</p> <p>-All food put in the refrigerator or freezer was to be sealed, labeled, and dated;</p> <p>-The cooks were responsible for putting left over food items in the refrigerator;</p> <p>-The cooks and the Dietary Manager (DM) were responsible for pulling items out of the refrigerator and freezer that were out of date.</p> <p>During an interview on [DATE], at 3:05 P.M., Dietary Aide (DA) T said the following:</p> <p>-The cooks were responsible for putting food in the refrigerator;</p> <p>-All food items in the refrigerator and freezer were to be sealed, labeled, and dated;</p> <p>-The DM was responsible for pulling items out of the refrigerator and freezer that were outdated.</p> <p>During an interview on [DATE], at 3:13 P.M., the DM said the following:</p> <p>-The DM, cooks, and DA were responsible for putting food in the refrigerator and freezers;</p> <p>-All food items were to be sealed, labeled, and dated prior to going in the refrigerator and freezer;</p> <p>-The DM and cooks were responsible for pulling out food items that were out of date.</p> <p>During an interview on [DATE], at 12:22 P.M., the Administrator said all food in the refrigerator and freezer should be labeled, dated, and sealed.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2. Review of the Food and Drug Administration (FDA) 2022 Food Code showed food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles.</p> <p>Review of the facility's policy titled, Dietary-Sanitary Procedures, revised [DATE], showed hair must be covered with a hairnet. Beards or any excessive body hair that may be exposed must be covered.</p> <p>Observation on [DATE], at 3:43 P.M., of the kitchen showed [NAME] R and the DM had facial hair that was not contained in a beard net.</p> <p>Observations on [DATE], at 8:48 A.M., and [DATE], at 11:41 A.M., of the kitchen showed the DM had facial hair that was not contained in the beard net. DA H had facial hair and did not wear a beard net.</p> <p>During an interview on [DATE], at 2:10 P.M., [NAME] S said the staff were to wear hair/beard nets at all times while in the kitchen or serving food.</p> <p>During an interview on [DATE], at 3:05 P.M., DA T said the staff were to wear hair and beard nets while in the kitchen and when handling food.</p> <p>During an interview on [DATE], at 3:13 P.M., the DM said all facial hair should be contained in the beard net.</p> <p>During an interview on [DATE], at 1:24 P.M., the Registered Dietician (RD) said staff were to wear hair and beard nets while in the kitchen and serving food.</p> <p>During an interview on [DATE], at 12:22 P.M., the Administrator said all staff are required to wear hair nets and beard nets when appropriate.</p> <p>3. Review of the FDA 2022 Food Code showed food employees shall keep their hands and exposed portions of their arms clean.</p> <p>Review of the facility's policy titled, Dietary-Sanitary Procedures, revised [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Hand washing is a priority for infection control;</li> <li>-Hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different foods substances, and following contact with any unsanitary surface;</li> <li>-Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food;</li> <li>-Gloves must be changed as often as hands need to be washed;</li> <li>-Gloves may be used for one task only.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on [DATE], at 11:41 A.M., of the puree process showed the following:</p> <ul style="list-style-type: none"> <li>-Cook S gathered the blender bowl, blade, lid, and spatula to puree food items;</li> <li>-Cook S did not wash his/her hands;</li> <li>-Cook S used tongs to put one piece of cake in the blender bowl, pureed the cake then poured in metal pan;</li> <li>-Cook S removed the blender bowl, blade and lid and washed then rinsed the items;</li> <li>-Cook S using tongs placed one piece of pork in blender bowl, pureed pork then poured into metal pan;</li> <li>-Cook S removed blender bowl, blade, and lid and washed then rinsed the items;</li> <li>-Cook S did not wash his/her hands or don/doff (put on/remove) gloves during this process.</li> </ul> <p>During an interview on [DATE], at 2:10 P.M., [NAME] S said hand hygiene was to be done when entering the kitchen, before and after don/doffing gloves, after washing dishes, and taking trash out.</p> <p>During an interview on [DATE], at 3:05 P.M., DA T said staff should wash hands between every ask and prior to donning and after doffing gloves.</p> <p>During an interview on [DATE], at 3:13 P.M., the DM said hand hygiene was to be done when staff entered the kitchen, between different task, and when donning gloves and after doffing gloves. Staff were to change gloves and wash hands when going from serving items to direct food contact.</p> <p>During an interview on [DATE], at 1:24 P.M., the RD said the staff were to use hand hygiene between different task, prior to donning gloves and after doffing gloves, and after any contact with a non-sanitary surface.</p> <p>During an interview on [DATE], at 12:22 P.M., the Administrator said staff should be doing hand hygiene when entering the kitchen, after washing dishes, and when going from non-food contact surfaces to direct food contact.</p> <p>4. Review of the FDA 2022 Food Code showed the presence of adequate detergents and sanitizers is necessary to effect clean and sanitized utensils and equipment.</p> <p>Review of the facility's policy titled, Dietary Food Preparation, revised [DATE], showed staff to wash, rinse, and sanitize a metal probe-type thermometer with alcohol wipe. Staff to re-sanitize the thermometer after each use.</p> <p>Review of the facility's policy titled, Dietary - Equipment Operations, Infection Control, and Sanitation Policy, revised on [DATE], showed the Robot Coupe (food processor) to be washed after each use and sanitation of equipment completed after each use. Allow all items to air dry.</p> <p>Observation on [DATE], at 11:41 A.M., of the puree process showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Cook S gathered the blender bowl, blade, lid, and spatula to puree food items;</p> <p>-Cook S used tongs to put one piece of cake in the blender bowl, pureed the cake, then poured it in a metal pan;</p> <p>-Cook S removed the blender bowl, blade, and lid and washed then rinsed the items. [NAME] S did not sanitize the equipment or let the equipment dry;</p> <p>-Cook S used tongs and placed one piece of pork in blender bowl, pureed the pork, then poured it in a metal pan;</p> <p>-Cook S removed blender bowl, blade, and lid and washed then rinsed the items. [NAME] S did not sanitize the equipment or let the equipment dry.</p> <p>Observation on [DATE], at 11:59 A.M., of the lunch serve out showed the following:</p> <p>-Cook S used a digital thermometer to check temperatures of the food items on the steam table prior to serve out;</p> <p>-Cook S checked the temperature of the hamburgers, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the mechanical pork, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the pureed pork, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the pureed spinach, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the mechanical hamburger, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the gravy, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the pureed potato salad, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the pork tender, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the spinach, then rinsed the thermometer under hot water;</p> <p>-Cook S checked the temperature of the potato salad, then rinsed the thermometer under hot water;</p> <p>-Cook S did not wash wash the thermometer with soap or sanitize the thermometer during this process.</p> <p>Observation on [DATE], at 11:57 A.M., of the lunch serve out showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Cook S used a digital thermometer to check temperatures of the food items on the steam table prior to serve out;</p> <p>-Cook S rinsed the thermometer under hot water between each food item;</p> <p>-Cook S let the handle of the thermometer rest directly on the noodles while taking the temperature;</p> <p>-Cook S let the handle of the thermometer rest directly on the zucchini and onions [NAME] take the temperature;</p> <p>-Cook S did not wash or run the handle of the thermometer under water between food items;</p> <p>-Cook S did not wash wash the thermometer with soap or sanitize the thermometer during this process.</p> <p>Observation on [DATE], at 12:22 P.M., of the lunch serve out showed the following:</p> <p>-The DM rinsed the thermometer under hot water, then touched it with the oven mitt he/she was wearing;</p> <p>-The DM used the thermometer to check the temperature of the pureed chicken;</p> <p>-The DM then ran the thermometer under hot water;</p> <p>-The DM used the thermometer to check the temperature of milk cartons;</p> <p>-The DM did not wash wash the thermometer with soap or sanitize the thermometer during this process.</p> <p>During an interview on [DATE], at 2:10 P.M., [NAME] S said the following:</p> <p>-All dishes were to be washed with soap, rinsed, and sanitized after each use;</p> <p>-The food processor bowl, blade and lid were to be washed, rinsed, and sanitized after each use;</p> <p>-All dishes were to be dry before staff used them;</p> <p>-The thermometer was probably supposed to be washed with something besides water between separate food items;</p> <p>-The handle of the thermometer was not to touch food directly.</p> <p>During an interview on [DATE], at 3:05 P.M., DA T said the following:</p> <p>-All dishes were to be washed with shop after each use;</p> <p>-All dishes were to be dry prior to using them.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE], at 2:10 P.M., [NAME] S said there should be no peeling paint on the ceiling. The paint chips could fall in the food, contaminating it, the food could be served to residents, and make the residents ill.</p> <p>During an interview on [DATE], at 3:13 P.M., the DM said when items in the kitchen needed repair, staff were to report them to the DM and the DM put the information in the maintenance book at the nurses' desk and the Maintenance Director took care of it. There should not be peeling paint on the ceiling in the kitchen. The peeling paint could fall in the resident food, contaminate it, and make the residents sick if eaten.</p> <p>During an interview on [DATE], at 3:46 P.M., the Assistant Maintenance Director said the following:</p> <ul style="list-style-type: none"> <li>-Staff were to log any maintenance request in the maintenance log book that was kept at the nurses station;</li> <li>-Kitchen maintenance requests were to be logged in the maintenance log book;</li> <li>-There were no maintenance request for the kitchen at this time.</li> </ul> <p>During an interview on [DATE], at 3:52 P.M., the Maintenance Director said the following:</p> <ul style="list-style-type: none"> <li>-There were two maintenance log books for staff to log maintenance request in;</li> <li>-Staff were to call the Maintenance Director if there was an emergency request;</li> <li>-There was not to be any peeling, or chipping paint, or dirty, dusty ceilings in the kitchen;</li> <li>-The maintenance department had a monthly cleaning schedule for the vents in the building, including the kitchen;</li> <li>-Peeling paint could fall into food being prepared for residents and contaminate it, and make the residents sick if consumed;</li> <li>-There were no pending maintenance request for the kitchen.</li> </ul> <p>During an interview on [DATE], at 12:22 P.M., the Administrator said there should not be peeling paint, dirt, or dust on the ceiling or vents in the kitchen.</p> <p>During an interview on [DATE], at 1:24 P.M., the RD said there should be no peeling paint or dust on vents in the kitchen.</p> <p>6. Review of the facility's policy titled, Resident Food Storage, revised [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-The purpose of the policy was to ensure that resident food storage was safe with sanitary storage, handling, and consumption;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Resident personal refrigerators will be monitored on a daily basis by facility staff;</p> <p>-Each refrigerator will have a temperature log and will be documented daily;</p> <p>-Food items will be dated after opening;</p> <p>-Prepared food that is dated 3 days after it is placed in the refrigerator will be discarded;</p> <p>-Food brought into the facility by visitors will be stored in the resident's refrigerator if temperature maintenance is required.</p> <p>Review of the Resident Room Weekly Cleaning List showed it did not contain a task for staff to check/clean resident room refrigerators.</p> <p>Observation on [DATE], at 4:43 P.M., of Resident #31's room refrigerator showed the following:</p> <p>-A [NAME] jack cheese stick with an expiration date of [DATE];</p> <p>-A bag of sliced cheese with mold growing on several pieces of cheese;</p> <p>-A container of mild guacamole that had been opened and was black in color;</p> <p>-A 12 ounce container of chicken salad with a use by date of [DATE].</p> <p>During an interview on [DATE], at 1:00 P.M., Resident #31 said the following:</p> <p>-The resident's spouse brings food for him/her;</p> <p>-The resident's child cleans his/her refrigerator for him/her;</p> <p>-The staff do not check the resident's refrigerator.</p> <p>Observation on [DATE], at 4:46 P.M., of Resident #45's room refrigerator showed the following:</p> <p>-On the top shelf was a paper plate that contained three food items that were dried out and not dated;</p> <p>-A 16 ounce container of bologna with an expiration date of [DATE];</p> <p>-A TV dinner that was open, with brown napkins sitting on top of it, and the food was covered with mold;</p> <p>-An individual serving bowl from the kitchen that contained fruit that was not sealed or dated.</p> <p>Observation on [DATE], at 9:34 A.M., of Resident #51's room refrigerator showed the following:</p> <p>-A brown, orange, and green substance on the bottom of the refrigerator;</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Three cartons of frozen shakes which had been recalled;</p> <p>-A serving bowl from the kitchen that contained a piece of cake, not dated and unsealed;</p> <p>-In the freezer section were two single serve containers of ice cream, one chocolate, one vanilla that were no longer frozen. The resident also had a hairbrush in the freezer.</p> <p>During an interview on [DATE], at 3:13 P.M., the DM said environmental services were responsible for monitoring resident room refrigerators.</p> <p>During an interview on [DATE], at 9:28 A.M., Housekeeper (HK) U said the following:</p> <p>-The housekeepers were responsible for checking temperatures of resident refrigerators and cleaning them;</p> <p>-The Housekeeping Supervisor verified the refrigerators were checked and cleaned;</p> <p>-Residents could get sick from eating/drinking expired/spoiled food in their refrigerators.</p> <p>During an interview on [DATE], at 1:47 P.M., the Environmental Service Director (ESD) said the following:</p> <p>-The housekeepers were responsible for checking resident refrigerators daily;</p> <p>-The ESD was to check them weekly;</p> <p>-Housekeepers and the ESD were responsible for checking for expired or spoiled food in resident refrigerators;</p> <p>-The residents could get sick from eating expired or spoiled food.</p> <p>During an interview on [DATE], at 12:22 P.M., the Administrator said the following:</p> <p>-Environmental services was responsible for checking resident room refrigerators daily for temperature and expired/recalled food;</p> <p>-All expired and spoiled food was to be discarded by staff when cleaning the refrigerators.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34871</p> <p>Based on interview and record review, the facility failed to maintain a complete medical record for all residents, when staff failed to document in the medical record a change in condition and transfer to the hospital for one resident (Resident #1). The facility census was 59.</p> <p>Review of the facility's policy titled, Resident Transfer, Discharge, Immediate Discharge and Therapeutic Leave Policy, dated 05/14/24, showed with the exception of ceasing to operate, the resident's medical record must be documented with the reason(s) for any facility-initiated transfer or discharge.</p> <p>Review of Resident #1's face sheet (admission data) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included essential hypertension (high blood pressure), edema (swelling caused by fluid building up in body tissues, and presence of cardiac pacemaker.</li> </ul> <p>Review of the resident's Facility Transfer Sheet, dated 02/19/25, showed the resident was discharged to the hospital on 02/19/25 for a medical reason, decreased level of function, and recent decline in activities of living functioning physically.</p> <p>Review of the resident's progress notes showed staff did not document related to the resident's change of condition or transfer on 02/19/25.</p> <p>During an interview on 02/27/25, at 11:55 A.M., the Care Plan Coordinator said the nurse should document any change in condition or if a resident passes away in the progress notes. He/she did not see a progress note for the resident's discharge on 02/19/25.</p> <p>During an interview on 02/27/25, at 12:05 P.M., the Director of Nursing said the following:</p> <ul style="list-style-type: none"> <li>-When a resident had a change in condition, the nurse should document in the resident's progress note;</li> <li>-The nurse should document the change in condition, the situation, and the transfer to the hospital;</li> <li>-She did not see a progress note for the resident's discharge on 02/19/25.</li> </ul> <p>During an interview on 02/28/25, at 11:11 A.M., the Administrator said nursing staff should have documented the resident's discharge to the hospital on 02/19/25.</p>		

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<p>F 0843</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care.</p> <p>41787</p> <p>Based on record review and interview, the facility failed to ensure that a written transfer agreement with a hospital was in effect to ensure residents timely admission to the hospital when medically appropriate and that information would be exchanged between providers. The facility census was 59.</p> <p>Review showed the facility did not provide a policy pertaining to written transfer agreements with a hospital or a written transfer agreement with a community hospital.</p> <p>During an interview on 02/27/25, at 3:30 P.M., the Administrator said he/she had not been able to locate a written transfer agreement. When the facility changed to new ownership in 2020, the facility applied at two local hospitals with no response. The facility had transfer agreements with other nursing homes and churches for emergency evacuation.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17193</p> <p>Based on observation, interview, and record review, the facility staff failed to establish and maintain an effective infection control program, when nursing staff failed to practice proper hand hygiene and infection practices while performing wound care for three residents (Residents #22, #31, and #13) and during catheter (a tube inserted in the bladder allowing your urine to drain freely) care for one resident (Resident #45) and when staff failed to gown as required for four residents (Residents #22, #31, #13, #45 ) who had enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO-microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device) in place. The facility also failed to complete the first step of a two step tuberculosis (TB - an infectious disease caused by bacteria that most often affects the lungs and can be spread through the air) skin screening test timely for four staff (Maintenance J, RN E, RN F, Housekeeper G), out of ten sampled staff, prior to the staff starting work in the facility with residents as per policy. The facility census was 59.</p> <p>Review of the facility policy Hand Hygiene, revised 06/26/24, showed the following:</p> <ul style="list-style-type: none"> <li>-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility;</li> <li>-Hand hygiene is a general term for cleaning hands by hand washing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR);</li> <li>-Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice;</li> <li>-Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty;</li> <li>-The use of gloves does not replace hand hygiene. If a task requires gloves, perform hand hygiene prior to donning (applying) gloves, and immediately after removing gloves.</li> </ul> <p>2. Review of the Centers for Disease Control and Prevention (CDC)'s Considerations for Use in Skilled Nursing Facilities (referring to EBP), dated 06/2021, showed the following information:</p> <ul style="list-style-type: none"> <li>-MDRO transmission is common in skilled nursing facilities, contributing to significant morbidity and mortality for residents and increased costs for the health care system;</li> <li>-EBP involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices);</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-EBP may be applied (when Contact Precautions do not otherwise apply) to residents with wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO;</p> <p>-Effective implementation of EBP required staff training on the proper use of personal protective equipment (PPE) and the availability of PPE with hand hygiene products at the point of care;</p> <p>-EBP to routine care of residents with wounds or indwelling medical devices requires that staff participate in initial and on-going training on the facility ' s expectations about hand hygiene and gown and glove use, along with proof of competency regarding appropriate use and donning and doffing (removing) technique for PPE;</p> <p>-Facilities should develop a method to identify residents with wounds or indwelling medical devices, and post clear signage outside of resident rooms indicating the type of PPE required and defining high risk resident care activities;</p> <p>-Gowns and gloves should be available outside of each resident room, and alcohol-based hand rub should be available for every resident room (ideally both inside and outside of the room);</p> <p>-A trash can (or laundry bin, if applicable) large enough to dispose of multiple gowns should be available for each room.</p> <p>Review of the facility policy Enhanced Barrier Precautions, revised 05/18/24, showed the following:</p> <p>-Implement EBP for the prevention of transmission of MDRO;</p> <p>-EBP is a strategy in nursing homes to decrease transmission of CDC targeted MDROs when contact precautions do not apply. EBP uses PPE and recommends gown and glove use for certain residents during specific high-contact resident care activities;</p> <p>-Gown and gloves must be used for wound and/or indwelling medical devices, high-contact resident care activities include, but are not limited to dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, indwelling device care or use, or wound care, brushing teeth or shaving;</p> <p>-Wounds that require EBP are chronic wounds, wounds that generally require a dressing, and any wound care;</p> <p>-Indwelling medical devices include central lines, urinary catheter, feeding tubes, and tracheotomies;</p> <p>-Make gowns and gloves available immediately near or outside of the resident's room. Face protection may also be needed if performing activity with risk of splash or spray such as wound irrigation;</p> <p>-Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room);</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room;</p> <p>-Provide education to residents and visitors;</p> <p>-EBP are intended to be placed for the resident's entire stay in the facility or until resolution of the wound or discontinuation of the indwelling device that placed them at higher risk;</p> <p>-The facility should ensure all staff and other health care providers (doctors, lab technicians, therapy providers) know which residents require EBP. Facility has the discretion on how to communicate to staff.</p> <p>1. Review of Resident #22's face sheet (admission information at a glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions), chronic kidney disease, and high blood pressure.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 12/07/24, showed the following:</p> <p>-The resident had modified cognition;</p> <p>-Resident had a stage one pressure ulcer (intact skin with non-blanchable redness of localized area usually over a bony prominence) or greater, a scar over bony prominence, or a non-removable dressing/device;</p> <p>-Resident had one stage 2 ulcer (partial thickness loss of dermis presenting as a shallow open ulcer);</p> <p>-Pressure ulcer care;</p> <p>-Application of ointments medications other than to feet;</p> <p>-Applications of dressing to feet.</p> <p>Review of the resident's care plan, revised 12/07/24, showed the following:</p> <p>-The resident had a stage 4 pressure ulcer (a full thickness tissue loss with exposed bone, tendon or muscle) to top of right foot;</p> <p>-The resident had a stage 2 pressure ulcer to the right heel.</p> <p>Review of the resident's February 2025 Physician's Orders and Treatment Administration Record (TAR) showed the following:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order, dated 01/2/2025, for staff 4 pressure ulcer to top of right foot. Staff were to cleanse wound with wound cleanser and apply Prisma (a sterile, advanced wound care product designed to promote wound healing) to wound bed. Cover with gauze and secure with kerlix (an absorbent, breathable, and protective gauze).</p> <p>-An order dated, 02/22/25, for stage 2 pressure ulcer on right heel. Staff to cleanse wound with wound cleanser and apply Prisma to wound bed. Cover with gauze and secure with kerlix.</p> <p>Observation on 02/24/25, at 10:05 A.M., showed the following:</p> <p>-The Director of Nursing (DON) walked into the residents' room and put on a pair of gloves without washing or sanitizing his/her hands. The DON did not don a gown. The room did not have EBP signage on the door. Gowns were located in the hall by the resident's door;</p> <p>-The resident was lying on the bed wearing non-slip socks. The DON asked the resident to get into the wheelchair by the bed. The resident moved over to the wheelchair;</p> <p>-The DON got on the floor and removed the resident's right non-slip sock and removed the dressing gauze wrap and the dressing on the resident's right ankle. The wound bed had dark copious slough (dead tissue that accumulates in a wound) and the dressing had moderate bloody drainage;</p> <p>-She said she would put a dressing on in a few minutes and pulled the same non-slip sock back on the resident's right foot while he/she sat in the wheelchair;</p> <p>-The DON then removed his/her gloves and washed his/her hands at the resident's sink before leaving the room.</p> <p>Observation on 02/25/25, at 8:50 A.M., showed the DON put on a protective gown that was outside the resident's door. There was no signage for EBP on the door. The DON put on gloves, without washing or sanitizing hands, and got the wound care supplies off the treatment cart;</p> <p>-The DON went into the resident's room to do his/her wound treatment. The resident lay on the bed with the right foot bandaged;</p> <p>-The DON set the supplies on plastic bags and on a towel placed on top of the bed cover. She said the resident's wound treatment did not change after going to the wound clinic yesterday. She removed the outer gauze and there was copious amount of purulent (a thick, milky and often foul-smelling discharge that could indicate infection) drainage. She removed the calcium alginate (highly absorbent wound dressing to aide healing) dressing. There was a slight odor she said;</p> <p>-The DON removed her gloves, did not wash or sanitize her hands, and put on new gloves;</p> <p>-The DON measured the stage 4 pressure ulcer and the stage 2 pressure ulcer;</p> <p>-The DON removed gloves and used hand sanitizer from her pocket;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The DON sprayed wound cleanser on top of the foot/ankle and wiped around the area and then used gauze to wipe the area. She used several gauze pads to wipe the top of the foot and ankle which bled a little;</p> <p>-The DON changed gloves, without washing or sanitizing hands, and put Maxorb (for moderate to heavily drainage for partial and full-thickness wounds) dressing and then covered it with the ABD (abdominal gauze to absorb heavy drainage) on both top and bottom of foot and wrapped with gauze;</p> <p>-She gathered the dressings and placed them in the bag, used hand sanitizer she had in her pocket, carried the wound cleanser bottle and the scissors and dropped off the trash in the soiled utility room. The DON then used the hand sanitizer on the hall to sanitize her hands.</p> <p>2. Review of Resident #31's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included chronic respiratory failure, type 2 diabetes mellitus (high blood sugar), heart failure, and chronic gout (a form of arthritis that causes severe pain, swelling, redness, and tenderness in joints).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was interviewable and had a stage 2 pressure ulcer.</p> <p>Review of the resident's care plan, updated 01/31/25, showed the following:</p> <p>-The resident had potential/actual impairment to skin integrity of the right heel related to Stage 2 pressure injury;</p> <p>-Staff to cleanse with wound cleanser and apply iodine. Cover with dry dressing and secure with conforming gauze;</p> <p>-Staff to monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to physician.</p> <p>(Staff did not care plan EBP.)</p> <p>Observation on 02/24/25, at 10:43 A.M., showed the following:</p> <p>-The resident sat in a recliner in his/her room. There was no EBP sign on the door;</p> <p>-The resident's right heel was up on the footrest and there was no dressing covering the pressure ulcer which appeared to be a stage 3 pressure ulcer (full thickness tissue loss where subcutaneous fat may be visible but bone, tendon or muscle is not exposed).</p> <p>Review of the resident's February 2025 Treatment Administration Record (TAR) showed an order, dated 02/05/25, to cleanse with wound cleanser and apply iodine. Cover with dry dressing and secure with conforming gauze every day shift for stage 2 pressure wound to right heel.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation on 02/24/25, at 10:43 A.M., showed there was no EBP signage on the door or side of the wall.</p> <p>Observation on 02/24/25, at 10:46 A.M., showed the following:</p> <ul style="list-style-type: none"> <li>-The DON entered the resident's room without washing or sanitizing hands or putting on a gown and put on gloves. The resident had his/her right foot open and uncovered and up on the recliner footrest.</li> <li>-The DON said the drainage was serosanguinous (mixture of clear (serous) fluid and blood) but had been more bloody (sanguinous). She got the measurement tape and measured the wound;</li> <li>-The DON removed her gloves, did not wash or sanitize her hands, went out to the treatment cart in the hall, got treatment supplies out of the treatment cart including a small bottle of iodine, 2 inch by 2 inch gauze, and placed in a plastic cup, gauze wrap, and wound cleanser;</li> <li>-She put on a pair of gloves, without washing or sanitizing hands, and then placed the treatment supplies on top of the resident's bedside table after moving the resident's water glass and other items over to the side on the bedside table, and without sanitizing the bedside table;</li> <li>-The DON put the 2 inch by 2 inch gauze in the plastic cup and poured iodine over the gauze. She then sprayed wound cleanser into the resident's pressure ulcer and wiped with gauze. She removed her gloves, and washed hands at the bathroom sink. There were no paper towels in the bathroom and had to ask staff in the hall to bring her paper towels;</li> <li>-She put on gloves and put the 2 inch by 2 inch iodine gauze over the pressure ulcer on the heel. She put an ABD dressing and gauze over this due to the large amount of drainage, she said. Then she placed the non-slip sock over the right foot with the dressing;</li> <li>-She removed his/her gloves and put them in the trash. Without washing or sanitizing hands, she put the remaining dressing supplies back on the cart and removed the small garbage bag with the soiled dressing and trash to the soiled utility room down the hall. On the way back down the hall, she used the alcohol sanitizer on the wall.</li> </ul> <p>3. Review of Resident #13's face sheet, showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> <li>-Diagnoses included lymphoma (type of cancer that affects the lymphatic system part of the body's immune system), peripheral vascular disease (reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), type 2 diabetes mellitus, schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responses, and social interactions).</li> </ul> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> <li>-Moderately impaired cognition, made poor decisions, and required cues and supervision;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-At risk for developing pressure ulcers;</p> <p>-No unhealed pressure ulcer or other open lesion on the foot;</p> <p>-No infection of the foot.</p> <p>Review of the resident's care plan, initiated on 01/01/25 and revised on 02/25/25, showed the following:</p> <p>-Staff to monitor for side effects of the antibiotics and report failure to heal and signs and symptoms of infection to physician;</p> <p>-Potential/actual impairment to skin integrity of the right foot, 3rd toe (stage 2 wound);</p> <p>-Cleanse with wound wash or saline. Cover with iodine soaked gauze and ABD. Secure entire foot with conforming gauze and tape. Change dressing daily until resolved.</p> <p>(Staff did not care plan related to EBP.)</p> <p>Review of the resident's physician's order, dated 02/21/25, showed an order for Keflex (an antibiotic) oral capsule 500 milligrams (mg) give one capsule by mouth two times a day for right foot infection for 8 days.</p> <p>Review of the resident's physician's order, dated 02/23/25, showed staff were to cleanse with wound wash or saline. Cover with iodine soaked gauze and ABD pad. Secure entire foot with conforming gauze and tape. Change dressing daily until resolved for stage 2 wound to right foot 3rd toe.</p> <p>Observation and interview on 02/24/25, at 2:54 P.M., showed the following:</p> <p>-The DON gathered the wound care supplies from the treatment cart and entered the resident's room where the resident sat in the wheelchair at the bedside table;</p> <p>-The DON placed the dressings and supplies on the bedside table without sanitizing the table and/or laying a protective covering on top for the wound care supplies;</p> <p>-Without washing or sanitizing hands or putting on a protective barrier gown, the DON put on gloves, and removed the resident's non-slip sock. She unwrapped the gauze on his/her foot. The right foot was slightly swollen.</p> <p>-The DON used wound cleanser and gauze to clean the right third toe. The third toe was open, with yellow serous drainage. She removed her gloves, sanitized hands, and then went to get more gloves. She put a towel on the floor for the resident to rest his/her right foot on it;</p> <p>-She measured the stage 2 pressure ulcer on the third right toe;</p> <p>-The DON took a 2 inch by 2 inch gauze saturated with iodine and placed on the third toe. She asked the resident to leave the dressing on it;</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-She changed gloves, without washing and/or sanitizing hands, and put the ABD pad over this and wrapped the foot with gauze;</p> <p>-The DON put the soiled dressing and wrap in the trash to remove it. She removed the trash bags, wearing the same gloves, down the hall to the soiled utility room. She used the hand sanitizer from the sanitizer on the wall after leaving the soiled utility room.</p> <p>4. Review of the facility's policy titled, Catheter Care, revised 06/26/24, showed the following:</p> <p>-It is the policy of the facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use;</p> <p>-Perform hand hygiene;</p> <p>-Don gloves and gown.</p> <p>Review of Resident #45's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnosis included urinary tract infection (bladder infection), bacteremia (bacteria are present in the bloodstream), and cellulitis (common and potentially serious bacterial skin infection).</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident had an indwelling urinary catheter.</p> <p>Review of the resident's care plan, updated 02/20/25, showed the following:</p> <p>-The resident had a urinary catheter;</p> <p>-Staff were to position catheter bag and tubing below the level of the bladder;</p> <p>-Staff to monitor, record, and report to physician for signs and symptoms of urinary tract infection such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased temperature, urinary frequency, foul smelling urine, altered mental status, change in behavior, change in eating patterns.</p> <p>-The resident had a urinary tract infection. Staff to check at least every two hours for incontinence.</p> <p>-Staff were to wash, rinse, and dry soiled areas. Give antibiotic therapy as ordered and monitor and document for side effects and effectiveness.</p> <p>(Staff did not care plan EBP.)</p> <p>Review of the resident's February 2025 Physician Order Summary Report showed the following:</p> <p>-An order, dated 09/18/24, to change catheter every 28 days for urinary retention;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order, dated 09/18/24, for catheter care every shift, every day and night shift.</p> <p>Observation on 02/24/25, 3:34 P.M., showed the following:</p> <p>-There was no sign on the door for EBP;</p> <p>-The resident was in the recliner. The resident's catheter bag was laying on the floor under the foot stool of the resident's recliner;</p> <p>-Certified Nurse Aide (CNA) M was in the resident's room and did not have a protective gown and gloves on;</p> <p>-In an attempt to move the resident's catheter out of the way, CNA M picked up the catheter bag without washing his/her hands or donning gloves;</p> <p>-The catheter bag fell out of the dignity bag, while CNA M was moving it. CNA M without washing his/her hands or donning gloves, put the catheter bag back in the dignity bag and moved it from the floor beside the recliner;</p> <p>-CNA M picked up the empty catheter bag off the floor and attached the catheter bag on the side of the resident's recliner. The bag fell off and the CNA left it on the floor;</p> <p>-CNA M left the resident's room without washing his/her hands.</p> <p>During an interview on 02/26/25, at 11:08 A.M., CNA O said catheter bags were to be kept off the floor.</p> <p>During an interview on 02/26/25, at 6:42 P.M., CNA N said the residents' catheter/dignity bags were to be kept off the floor.</p> <p>During an interview on 02/26/25, at 1:23 P.M., the DON said resident's catheter bags were to be kept in a dignity bag and kept off the floor. Staff were to wash hands and don gloves prior to repositioning a catheter/dignity bag. Staff should doff gloves and wash hands after contact with a catheter/dignity bag.</p> <p>During an interview on 02/28/25, at 10:13 A.M., the Administrator said all resident catheter bags were to be in dignity bags and were to be kept off the floor.</p> <p>5. During an interview on 02/28/25, at 8:30 A.M., CNA L said they were to wash hands after touching personal belongings and wash or sanitize hands when they remove gloves and before putting on gloves. He/she washed hands before serving food, and when he/she went into a resident' s room. They were to wash hands during perineal care. EBP was for staff to put on PPE, a gown and gloves, if the resident had a catheter, was sick, or had a wound.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 02/28/25, at 8:44 A.M., Nurse Aide (NA) K said they were to wash hands before going into a room and after care and when they leave the resident's room. They were to wash hands during perineal care and when they assist the resident with showers. They were to wash or sanitize hands before putting on gloves and when removing gloves, and after assisting residents' cares. They had not gone over EBP with him/her.</p> <p>During an interview on 02/28/25, at 8:13 A.M., Licensed Practical Nurse (LPN) Q said staff were to wash hands before and after care, touching belongings, transmission like coughing, and soiled clothing. Staff should wash and reapply gloves after these events. Staff should wash hands before donning gloves and after removing gloves. EBP is for wearing PPE like gowns, gloves, face shields, and masks . Residents with catheters, wounds, peg tubes, and any openings into the body should EBP.</p> <p>During an interview on 02/28/25, at 11:29 A.M., the DON said she would expect staff to wash hands before and after any cares, touching things, and especially if hands were visibly soiled to prevent infection. Staff were to wash hands before and after gloving and during wound care treatment. Staff can use hand sanitizer between, but must wash hands. EBP is fairly new and they were trying to implement and have struggled with this. Staff know to wear gowns with cares such as catheters care and showers, but did not understand wearing gowns with transfers.</p> <p>During an interview on 02/28/25, on 10:21 A.M., the Administrator said he would expect staff to wash hands after cares, when handling food, and between personal cares. Staff can sanitize hands, but it was not to substitute this for hand washing. After the third time for using hand sanitizer, they were to wash hands. They were to take off gloves and wash hands and wash hands before donning gloves. They try to educate monthly about EBP. EBP was for staff to wear gloves and gowns for those who have catheters, any artificial openings in body, or wound. They do have the set up outside resident's doors with gowns and gloves.</p> <p>41787</p> <p>6. Review of the facility policy titled Tuberculosis Testing, dated 06/29/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Staff to ensure each resident and employee of the facility is tested for TB after entering the facility to prevent the spread of infection;</li> <li>-Upon hire, a new employee will receive a two-step TB skin test;</li> <li>-Each employee will also have an annual one-step TB test to ensure any possible infections can be trigger proactively to prevent further spread;</li> <li>-If the new hire has had a positive reaction history to previous TB test, a chest x-ray will be done;</li> <li>-All TB tests and chest x-ray records will be kept on file in the employee files and resident records.</li> </ul> <p>Review of the facility policy titled Infection Prevention and Control Program, dated 05/07/24, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease as per accepted national standards and guidelines;</p> <p>-Direct care staff shall be tested for TB upon hire.</p> <p>7. Review of Maintenance J's personnel record showed the following:</p> <p>-Hire date (resident contact date) of 01/27/25;</p> <p>-Staff documented first-step TB test administered on 02/03/25;</p> <p>-Staff documented first-step TB test as read on 02/05/25;</p> <p>-Staff documented second-step TB test administered on 02/17/25;</p> <p>-Staff documented first-step TB test as read on 2/19/25.</p> <p>8. Review of Register Nurse (RN) E's personnel record showed the following:</p> <p>-Hire date (resident contact date) of 10/18/24;</p> <p>-Staff documented first-step TB test administered on 10/25/24;</p> <p>-Staff documented first-step TB test as read on 10/28/24;</p> <p>-Staff documented second-step TB test administered on 11/01/24;</p> <p>-Staff documented first-step TB test as read on 11/03/24.</p> <p>9. Review of RN F's personnel record showed the following:</p> <p>-Hire date (resident contact date) of 10/02/24;</p> <p>-Staff documented first-step TB test administered on 10/07/24;</p> <p>-Staff documented first-step TB test as read on 10/09/24;</p> <p>-Staff documented second-step TB test administered on 10/23/24;</p> <p>-Staff documented first-step TB test as read 10/25/24.</p> <p>10. Review of Housekeeper G's personnel record showed the following:</p> <p>-Hire date (resident contact date) of 02/17/25;</p> <p>-Staff documented first-step TB as administered on 02/19/25;</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staff documented first-step TB test as read on 02/21/25.</p> <p>11. During an interview on 02/27/25, at 1:15 P.M., the Business Office Manager (BOM) said once the newly hired employee completed the online onboarding process, the employee is sent to MDS Coordinator or DON to start the TB test process and it should be completed before working on the floor.</p> <p>During an interview on 02/27/25, at 2:00 P.M., MDS Coordinator said the BOM sends a new staff to him/her during orientation. He/she administered the TB test, and the staff are to have any nurse read the test 48 to 72 hours later. The second step was completed in two weeks. He/she did not know what the policy stated when the staff can start work on the floor related to the TB test results.</p> <p>During an interview on 02/27/25, at 2:50 P.M., the DON said newly hired staff generally go to the MDS Coordinator for TB testing and should have the first-step read within 48 to 72 hours and before working with residents.</p> <p>During an interview on 02/27/25, at 2:20 P.M., Administrator said new hired staff should have first-step of the TB testing the day they accept the job offer and should be completed before starting on the floor.</p> <p>48534</p> <p>34871</p>

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NAME OF PROVIDER OR SUPPLIER  Nathan Richard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 East Highland Avenue Nevada, MO 64772	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement a program that monitors antibiotic use.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17193</p> <p>Based on interview and record review, the facility failed to implement an effective and complete antibiotic stewardship program, when staff failed to track residents on antibiotics for various infections in the facility by not completing a current and ongoing antibiotic log of residents with active infections including three residents (Residents #13, #31, and #45) identified as currently or recently on an antibiotic. The facility census was 59.</p> <p>Review of the facility policy Antibiotic Stewardship Program, revised 06/29/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Purpose was to optimize antibiotic use in the nursing home and reduce unnecessary use of laboratory tests and antibiotics using a systematic approach;</li> <li>-At minimum, the antibiotic stewardship program (ASP) will be comprised of the Director of Nursing (DON), a nurse with administrative duties, and a charge nurse;</li> <li>-The antibiotic stewardship team (AST) will work closely with the Administrator, nurses, physician, and prescribing practitioners to ensure success of the program;</li> <li>-The facility pharmacy consultant will consult and serve as the pharmacy leader for the program, and assist the team on working to improve antibiotic usage;</li> <li>-The facility will track and monitor antibiotic prescribing practices and resistance patterns among its residents;</li> <li>-The facility antibiotic steward will review and generate the Infection Log in the electronic medical record;</li> <li>-At the end of each month, the facility antibiotic steward will print the Monthly Infection Log. This report will be placed in the ASP binder and the weekly reports from that month will be removed;</li> <li>-The facility antibiotic steward will report information on antibiotic use and resistance to the monthly quality assurance committee, physicians, prescribing practitioners, pharmacy consultant, facility nurses, and other relevant staff;</li> <li>-All antibiotics are entered into the physician's orders in the electronic medical record;</li> <li>-The facility antibiotic steward will review and audit the Infection Log weekly in the electronic medical record;</li> <li>-The Antibiotic Utilization Report will be used to collect and track antibiotic usage. The information included name, antibiotic name, indication for antibiotic, route of administration, dose of antibiotic, prescribed length of antibiotic course (days), and prescriber;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Additionally, the facility antibiotic steward will track antibiotic time-outs, recommended actions for evaluation of ongoing treatment needs, multi-drug resistant infections, consulting pharmacist recommendations, etc.;</p> <p>-The facility antibiotic steward will also educate facility licensed nursing staff during the new hire orientation period for the infection control/antibiotic usage documentation requirements;</p> <p>-The facility antibiotic steward and AST will establish facility criteria for their infection prevention and control program and initiating the use of antibiotics, using a nationally recognized surveillance criteria, McGeer, Loeb, or a modified Loeb as it starting point for making possible intervention recommendations to the providers based on the systematic data collected.</p> <p>1. Review of Resident #13's face sheet (admission information at a glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included lymphoma (type of cancer that affects the lymphatic system part of the body's immune system), peripheral vascular disease (PVD - reduced circulation of blood to a body part, other than the brain or heart, due to a narrowed or blocked blood vessel), type 2 diabetes mellitus (high blood sugar), and schizophrenia (mental disorder characterized by disruptions in thought processes, perceptions, emotional responses, and social interactions).</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 12/16/24, showed the resident had moderately impaired cognition and was not on an antibiotic within the last 7 days.</p> <p>Review of the resident's current care plan showed the following initiated 01/01/25:</p> <p>-Resident had a stage 2 wound (partial thickness loss of dermis presenting as a shallow open ulcer with a red, or pink wound bed. May also present as an intact or open/ruptured blister)) to third toe on the right foot;</p> <p>-Monitor for side effects of antibiotics;</p> <p>-Report failure to heal and signs and symptoms of infection to physician.</p> <p>Review of the resident's January 2025 Medication Administration Record (MAR) showed the following:</p> <p>-An order, dated 01/18/25, for clindamycin HCL (an antibiotic) oral capsule 200 milligrams (mg), give one capsule by mouth three times a day for right foot cellulitis (a bacterial skin infections) for seven days. Staff administered the medication as ordered 01/18/25 through 01/25/25.</p> <p>Review of the resident's February 2025 MAR showed the following:</p> <p>-An order, dated 02/15/25, for Keflex (an antibiotic) oral capsule 500 mg, give one capsule by mouth two times a day for right foot infection for 14 days. Staff administered the medication as ordered on 02/15/25 through 02/21/25;</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-An order, dated 02/22/25, for Keflex oral capsule 500 mg, five one capsule by mouth two times a day for right foot infection for eight days. Staff administered the medication as ordered on 02/22/25 through 002/27/25. (The order change was due to a physician change.)</p> <p>Review of the resident's record and facility records showed the facility did not provide an infection log or other tracking documentation related to antibiotic usage.</p> <p>2. Review of Resident #31's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included chronic respiratory failure, type 2 diabetes mellitus (high blood sugar), heart failure, and history of urinary tract infections (UTI).</p> <p>Review of the resident's current care plan showed staff initiated the following on 06/13/23;</p> <p>-The resident had a history of UTI;</p> <p>-Staff were to give antibiotic therapy as ordered, and monitor and document side effects and effectiveness.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was on an antibiotic.</p> <p>Review of the resident's current physician's orders showed an order, dated 09/24/24, for cephalexin (an antibiotic) oral tablet 250 mg, give one tablet by mouth one time a day for UTI prevention.</p> <p>Review of the resident's December 2024 and January 2025 MAR showed the facility staff administered the cephalexin as ordered.</p> <p>Review of the resident's February 2025 MAR showed the facility staff administered cephalexin oral tablet 250 mg, one tablet by mouth one time a day for UTI and was on hold from 02/01/25 through 02/06/25.</p> <p>Review of the resident's February 2025 MAR showed an order, dated 02/07/25, to administer Bactrim DS (an antibiotic) oral tablet 180 mg, give one tablet by mouth two times a day for UTI for three days. Staff administered the medication as ordered.</p> <p>Review of the resident's record and facility records showed the facility did not provide an infection log or other tracking documentation related to antibiotic usage.</p> <p>3. Review of Resident #45's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included UTI, type 2 diabetes mellitus, bacteremia (bacteria are present in the bloodstream), and cellulitis (common and potentially serious bacterial skin infection).</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was not on an antibiotic the prior seven days.</p> <p>Review of the resident's care plan showed staff initiated the following on 02/20/25;</p> <ul style="list-style-type: none"> <li>-The resident had a UTI;</li> <li>-Staff to administer antibiotic therapy as ordered;</li> <li>-Staff to monitor and document for side effects and effectiveness for antibiotic therapy.</li> </ul> <p>Review of the resident's February 2025 Medication Administration Record (MAR) showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 02/13/25, for ciprofloxin (an antibiotic for urinary tract infections) oral tablet 500 mg, administer one tablet by mouth two times a day related to urinary tract infection for seven days. Staff administered the medication as ordered on 02/13/25 through 02/20/25.</li> </ul> <p>Review of the resident's February 2025 Medication Administration Record (MAR) showed the following:</p> <ul style="list-style-type: none"> <li>-An order, dated 02/19/25, for linezolid (an antibiotic for certain bacterial infections) oral tablet 600 mg, administer one tablet by mouth every 12 hours related to pneumonia for a total of six days. Staff administered the medication as ordered on 02/20/25 through 02/23/25.</li> </ul> <p>Review of the resident's record and facility records showed the facility did not provide an infection log or other tracking documentation related to antibiotic usage.</p> <p>4. During an interview on 02/26/25, at 11:55 A.M., the Director of Nursing (DON) said she was the Infection Preventionist. She used to have an Assistant Director of Nursing (ADON) who assisted with the Infection Control and hoped to get another ADON soon. In their electronic medical record, she could review residents who had infections and utilize this and their lab site. She did not keep a record of antibiotics. When a former physician left the facility, in the fall, she did not keep up with the antibiotic review.</p>

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 17193</p> <p>Based on interview and record review, the facility failed to develop and implement policies to assure all residents were given the opportunity to receive pneumococcal vaccinations (pneumonia vaccines) when staff did not document offering the vaccine to two residents (Residents #11 and #31). The facility census was 59.</p> <p>Review of the Centers for Disease Control and Prevention (CDC) recommendations for pneumococcal vaccine, dated 10/26/24, showed the following:</p> <ul style="list-style-type: none"> <li>-There are two types of vaccines recommended to help prevent pneumococcal disease in adults;</li> <li>-One type of vaccine is the pneumococcal conjugate vaccines (PCVs): PCV15,PCV20,and PCV21;</li> <li>-One type of vaccine is the pneumococcal polysaccharide vaccine (PPSV23);</li> </ul> <p>-For older adults who received PCV13 and PPSV23, they have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they've already received both the PCV13 (but not PCV15 or PCV20) at any age or PPSV23 at or after the age of [AGE] years. These adults can talk with a vaccine provider and decide together, whether to get vaccinated (i.e., receive PCV20 or PCV21);</p> <p>-The CDC recommends PCV15, PCV20, or PCV21 vaccines for adults who never received a PCV and are ages [AGE] years or older or ages 19 through [AGE] years with certain risk conditions. If PCV15 is used, it should be followed by a dose of PPSV23.</p> <p>Review of the facility's policy Influenza and Pneumococcal Immunizations. revised 5/14/24, showed the following:</p> <ul style="list-style-type: none"> <li>-The purpose was to ensure that all residents residing in the facility were offered influenza and pneumococcal immunizations to prevent infection and the spread of communicable diseases;</li> <li>-As part of the admission process, the resident and/or the resident's legal representative will be provided education on the benefits and potential side effects of both the influenza and the pneumococcal immunization;</li> <li>-The resident or their legal representative will be informed that the pneumococcal immunization will be offered upon admission per the Centers for Disease Control (CDC) guidelines. The pneumococcal immunization will not be given if the immunization is medically contraindicated, or the resident or their legal representative has refused the immunization;</li> <li>-The resident or legal representative will be required to sign the revolving consent form which they can revoke at any time in writing;</li> <li>-The pneumococcal immunization will be offered upon admission and a second pneumococcal immunization may be recommended after five years from the first immunization;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Physician orders will be obtained for the immunizations unless medically contraindicated or the resident or their legal representative has refused the immunizations;</p> <p>-The resident's medical record will have documentation the resident or their legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization and if the resident received the pneumococcal immunization or did not receive it due to medical contraindications or refusal.</p> <p>1. Review of Resident #11's face sheet (admission information at a glance) showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included diabetes mellitus (high blood sugar), high blood pressure, anemia (a lack of red blood cells that leads to reduced oxygen flow to the body's organs), and muscle weakness.</p> <p>Review of the resident's Revolving Immunization Consent form signed by the guardian and the resident on admission 11//21/21, showed consent signed for the pneumococcal vaccine for the resident.</p> <p>Review of the resident's Vaccine Documentation and Consent Form showed the resident's guardian signed consent for the pneumonia vaccine on 08/12/24.</p> <p>Review of the resident's Missouri Immunization Record from the Missouri Show Me Vaccine portal showed the resident's pneumococcal vaccine was next due on 10/24/24.</p> <p>Review of the resident's medical record showed no documentation administration of a pneumococcal vaccine, no orders for administration of a pneumococcal vaccine, and no documentation between 10/24/24 and 02/28/25 regarding why the pneumococcal vaccine was not administered.</p> <p>During interviews on 02/27/25, at 3:24 P.M. and 5:00 P.M., the Director of Nursing (DON) said the resident's guardian signed the consent for a pneumonia vaccine on 11/15/21. The pneumonia was due 10/24/24.</p> <p>2. Review of Resident #31's face sheet showed the following:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included chronic respiratory failure (lung disorder), type 2 diabetes mellitus (high blood sugar), heart failure, high blood pressure, and acute kidney failure (kidneys suddenly can't filter waste from the blood).</p> <p>Review of the resident's Vaccine Documentation and Consent Form showed the resident signed consent for the pneumonia vaccine on 10/03/24.</p> <p>Review of the resident's Missouri Immunization Record from the Missouri Show Me Vaccine portal, showed the resident's pneumococcal vaccine PCV13 (Prevnar 13) was administered 9/18/18 and was next due on 09/18/19.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's medical record showed no documentation administration of the pneumococcal vaccine, no orders for administration of a pneumococcal vaccine, and no documentation between 10/03/24 and 02/28/25 regarding why the pneumococcal vaccine was not administered.</p> <p>During an interview on 02/27/25, at 4:44 PM, the resident said he/she would want a pneumonia shot if he/she signed to receive this vaccine.</p> <p>During interviews on 02/27/25, at 3:24 P.M. and 5:00 P.M., the DON said the resident signed the new vaccine form on 10/03/24. The resident had signed the consent for the pneumonia vaccine in his/her admission packet consent form on 02/13/23.</p> <p>3. During an interview on 02/28/25, at 8:13 A. M, Licensed Practical Nurse (LPN) Q said he/she did not administer immunizations to residents. The DON administered vaccines. The DON will send out a list of residents for them to monitor after having a vaccine.</p> <p>During interviews on 02/27/25, at 4:00 P.M. and 4:53 P.M., the Social Service Director (SSD) said the following:</p> <ul style="list-style-type: none"> <li>-He/she had a vaccine consent form different than the current vaccine consent form in the admission packet;</li> <li>-Nothing changed on the original vaccine consent form even though they signed it, and they were to notify the guardian and send out to double check with the guardian and/or Durable Power of Attorney (DPOA) about the pneumonia vaccine;</li> <li>-This past winter, they began using it and had guardians sign it;</li> <li>-He/she filled out the new vaccine consent form such as the resident's name, address, and then went to each resident and asked if they wanted a pneumonia vaccine and they signed it and said yes for the vaccine.</li> </ul> <p>During interviews on 02/27/25, at 3:24 P.M. and 5:00 P.M., the DON said the following:</p> <ul style="list-style-type: none"> <li>-She was the Infection Preventionist;</li> <li>-For the residents' flu vaccines, they did the flu vaccine first last fall, and then will do the pneumonia vaccines any time;</li> <li>-They haven't done any pneumonia vaccines since she has been at the facility since 2021;</li> <li>-She educates the residents about the pneumonia vaccine and tells the residents what to expect after receiving the pneumonia vaccine;</li> <li>-The physician told them to do the flu vaccines first;</li> <li>-If the resident was offered a pneumonia vaccine, wanted it, and requested to get this somewhere else like at the Veteran's (VA) clinic, health department, they would take them to do this;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-They can order the pneumonia vaccine.</p> <p>During an interview on 02/28/25, on 10:21 A.M., the Administrator said he expected vaccines such as the pneumonia vaccine ordered and provided if the resident requested a pneumonia vaccine.</p>

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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>41787</p> <p>Based on interview and record review, the facility failed to provide continued training for certified nursing aides (CNAs) that included competency evaluation as part of the required minimum 12 hours of in-service education per year. The facility census was 59.</p> <p>Review showed the facility did not provide a policy related to in-service training.</p> <p>1. Review of the facility's In-Service Training Records, on 02/27/25, showed no CNA competency evaluations.</p> <p>During an interview on 02/28/25, at 9:35 A.M., CNA L said he/she had attended in-services and training with the Administrator and Director of Nursing (DON). They will often demonstrate during the training, but he/she was not aware of being observed for proper care of residents.</p> <p>During an interview on 02/27/25, at 2:50 P.M., the DON said in-services and training included in-person and online training that was assigned to each staff member. He/she did not complete competency evaluations with nursing aides.</p> <p>During an interview on 02/27/25, at 3:07 P.M., the Corporate Nurse said there were no nurse aide competencies completed at the facility. Items such as handwashing return demonstration, were not completed at the facility.</p> <p>During an interview on 02/28/25, at 10:20 A.M., Administrator said there were two mandatory in-services per month and staff have assigned online training as well. He said there was no record of competencies completed.</p> <p>34871</p>