

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Marshfield Care Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 800 South White Oak Marshfield, MO 65706	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871</p> <p>Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to the hospital, including the reason for the transfer, for three residents (Resident #3, Resident #4 and Resident #30) who were selected out of a total sample of 18 residents with a facility census of 51.</p> <p>Review of the facility's policy titled Transfer or Discharge Documentation, revised December 2016, showed the following:</p> <p>-When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider;</p> <p>-When a resident is transferred or discharged from the facility the information documented in the medical record will include the basis for the discharge and that an appropriate notice was provided to the resident and/or legal representative.</p> <p>1. Review of Resident #3's face sheet (gives brief information about the resident) showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included acute kidney failure, schizophrenia (serious mental illness that affects how a person thinks, feels and behaves) and chronic obstructive pulmonary disease (COPD-common lung disease causing restricted airflow and breathing problems).</p> <p>Review of the resident's quarterly Minimum Data (MDS - a federally-mandated assessment form completed by facility staff), dated 06/18/24, showed cognitive skills intact.</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 05/11/24, at 3:48 P.M., a nurse documented the resident was in his/her room awake and alert in his/her bed. The resident's feeding tube was clogged and did not run. The nurse attempted to flush the feeding tube and was unable to obtain a flow. The nurse notified the on-call physician and received orders to send the resident out for a feeding tube exchange.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(Staff did not document providing the resident or his/her representative a written copy of discharge/transfer.)</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 06/04/24, at 8:35 P.M., a nurse documented nursing staff observed a change in the color and volume of the resident's gastric (a thin, clear, colorless acidic fluid secreted by the stomach glands and active in promoting digestion) contents in the drainage tube. At 6:00 P.M., staff emptied 750 milliliters (ml) of brown fluid with coffee ground looking sediment. The resident reported mild lower abdominal pain and sputum (a mixture of saliva and mucus coughed up from the respiratory tract). The resident's tube feeding still ran as ordered. Staff notified the on-call physician assistant. Staff called emergency medical services (EMS) and staff sent the resident to the hospital at 6:30 P.M.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of discharge/transfer.)</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 06/05/24, at 7:24 A.M., a night shift nurse reported that he/she was unable to flush the resident's feeding tube. The nurse attempted to flush the tube multiple times with no success. Staff notified the on-call provider. On 06/05/24, at 9:15 A.M., the on-call provider sent an order to send the resident to emergency room for evaluation and treatment.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of discharge/transfer.)</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 06/06/24, at 8:04 P.M., a nurse documented at 7:30 P.M. he/she tried to administer the resident's evening medications and proceeded to do a water flush and the tube it would not flush. The nurse called the on-call provider and staff sent the resident to the hospital 8:32 P.M.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of discharge/transfer.)</p> <p>Review of the resident's medical record showed staff did not document written notification, or have a copy of written notification, provided to the resident or resident's responsible party of the resident's transfer to the hospital.</p> <p>45176</p> <p>2. Review of Resident #4's face sheet showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's significant change MDS, dated [DATE], showed mild cognitive impairment.</p> <p>Review of the resident's progress note, dated 05/05/24, showed the following:</p> <p>-Resident stayed in bed for dinner;</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Resident threw up twice. Resident spiked a temperature of 101.8 degrees Fahrenheit (F);</p> <p>-Resident was clammy;</p> <p>-Staff called Durable Power of Attorney (DPOA) who wanted the resident sent to hospital;</p> <p>-Staff obtained orders to send resident to emergency room for evaluation;</p> <p>-Staff notified of the orders and resident sent out via ambulance.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of discharge.)</p> <p>Review of the resident's medical record showed staff did not have a copy of a letter provided to the resident or representative stating the date of transfer, destination of transfer, or the reason for transfer on 05/05/24 .</p> <p>Review of the resident's progress note, dated 06/14/24, showed the following:</p> <p>-Resident complained of severe stomach pain/nausea after breakfast and after receiving scheduled Zofran (medication to treat nausea);</p> <p>-Resident assessed and family requested resident be sent to the emergency room ;</p> <p>-Order received and resident transported to hospital by ambulance.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of discharge.)</p> <p>Review of the resident's medical record showed staff did not have a copy of a letter provided to the resident or representative stating the date of transfer, destination of transfer, or the reason for transfer on 06/14/24.</p> <p>48187</p> <p>3. Review of Resident #30's face sheet showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included COPD, high blood pressure, peripheral vascular disease (circulation disease caused by narrowed blood vessels), and diabetes.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Review of the resident's progress noted, dated 06/03/24, showed the following information:</p> <p>-Resident continued to have altered mental status and was running a temperature of 99.2 degrees F;</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Other facilities print out the transfer form out of the computer system to give to resident and/or the responsible party;</p> <p>-Staff should send the transfer form with the resident and/or responsible party when a resident is transferred to the hospital.</p>

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871</p> <p>Based on record review and interview, the facility failed to give written information to the resident and/or resident's representative of the facility's bed-hold policy for three residents (Resident #3, Resident #4 and Resident #30) who were transferred out to the hospital. A sample of three residents out of total sample of 18 were selected for review in a facility with a census of 51.</p> <p>Review of the facility's policy titled Bed Holds and Returns, undated, showed the following:</p> <p>-Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed hold and return policy;</p> <p>-Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail the rights and limitations of the resident regarding bed-holds; the reserve bed payment policy as indicated by the state plan (medicaid residents); the facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (medicaid residents); and the details of the transfer.</p> <p>1. Review of Resident #3's face sheet (gives brief information about the resident) showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included acute kidney failure, schizophrenia (serious mental illness that affects how a person thinks, feels and behaves) and chronic obstructive pulmonary disease (COPD-common lung disease causing restricted airflow and breathing problems).</p> <p>Review of the resident's quarterly Minimum Data (MDS - a federally-mandated assessment form completed by facility staff), dated 06/18/24, showed cognitive skills intact.</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 05/11/24, at 3:48 P.M., a nurse documented the resident was in his/her room awake and alert in his/her bed. The resident's feeding tube was clogged and did not run. The nurse attempted to flush the feeding tube and was unable to obtain a flow. The nurse notified the on-call physician and received orders to send the resident out for a feeding tube exchange.</p> <p>(Staff did not document providing the resident or his/her representative a copy of the bed hold policy.)</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 06/04/24, at 8:35 P.M., a nurse documented nursing staff observed a change in the color and volume of the resident's gastric (a thin, clear, colorless acidic fluid secreted by the stomach glands and active in promoting digestion) contents in the drainage tube. At 6:00 P.M., staff emptied 750 milliliters (ml) of brown fluid with coffee ground looking sediment. The resident reported mild lower abdominal pain and sputum (a mixture of saliva and mucus coughed up from the respiratory tract). The resident's tube feeding still ran as ordered. Staff notified the on-call physician assistant. Staff called emergency medical services (EMS) and staff sent the resident to the hospital at 6:30 P.M.</p> <p>(Staff did not document providing the resident or his/her representative a copy of the bed hold policy.)</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 06/05/24, at 7:24 A.M., a night shift nurse reported that he/she was unable to flush the resident's feeding tube. The nurse attempted to flush the tube multiple times with no success. Staff notified the on-call provider. On 06/05/24, at 9:15 A.M., the on-call provider sent an order to send the resident to emergency room for evaluation and treatment.</p> <p>(Staff did not document providing the resident or his/her representative a copy of the bed hold policy.)</p> <p>Review of the resident's nurses' notes showed the following:</p> <p>-On 06/06/24, at 8:04 P.M., a nurse documented at 7:30 P.M. he/she tried to administer the resident's evening medications and proceeded to do a water flush and the tube it would not flush. The nurse called the on-call provider and staff sent the resident to the hospital 8:32 P.M.</p> <p>(Staff did not document providing the resident or his/her representative a copy of the bed hold policy.)</p> <p>Review of the resident's medical record showed staff did not document written notification of bed hold provided, or have a copy of written notification of bed hold, provided to the resident or resident's responsible party of the resident's transfer to the hospital.</p> <p>45176</p> <p>2. Review of Resident #4's face sheet showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's significant change MDS, dated [DATE], showed mild cognitive impairment.</p> <p>Review of the resident's progress note, dated 05/05/24, showed the following:</p> <p>-Resident stayed in bed for dinner;</p> <p>-Resident threw up twice. Resident spiked a temperature of 101.8 degrees Fahrenheit (F);</p> <p>-Resident was clammy;</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Staff called Durable Power of Attorney (DPOA) who wanted the resident sent to hospital;</p> <p>-Staff obtained orders to send resident to emergency room for evaluation;</p> <p>-Staff notified of the orders and resident sent out via ambulance.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of bed hold policy.)</p> <p>Review of the resident's medical record showed staff did not have a copy of a written bed hold policy provided to the resident or representative on 05/05/24 .</p> <p>Review of the resident's progress note, dated 06/14/24, showed the following:</p> <p>-Resident complained of severe stomach pain/nausea after breakfast and after receiving scheduled Zofran (medication to treat nausea);</p> <p>-Resident assessed and family requested resident be sent to the emergency room ;</p> <p>-Order received and resident transported to hospital by ambulance.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of bed hold policy.)</p> <p>Review of the resident's medical record showed staff did not have a copy of a written notice of bed hold provided to the resident or representative on 06/14/24.</p> <p>48187</p> <p>3. Review of Resident #30's face sheet showed the following information:</p> <p>-admitted [DATE];</p> <p>-Diagnoses included COPD, high blood pressure, peripheral vascular disease (circulation disease caused by narrowed blood vessels), and diabetes.</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact.</p> <p>Review of the resident's progress noted, dated 06/03/24, showed the following information:</p> <p>-Resident continued to have altered mental status and was running a temperature of 99.2 degrees F;</p> <p>-Resident was given acetaminophen;</p> <p>-Resident continued to decline in alertness and mental state;</p> <p>-Physician in the building assessed the resident;</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Physician recommended sending the resident to the Emergency Department;</p> <p>-Staff notified the resident's family of transfer;</p> <p>-Resident sent to the Emergency Department via ambulance.</p> <p>(Staff did not document providing the resident or his/her representative a written copy of the bed hold policy.)</p> <p>Review of the resident's medical record showed staff did not have a copy of a bed hold policy provided to the resident or representative for transfer on 06/03/24.</p> <p>Review of the resident's medical record showed staff did not document providing notice of a bed hold agreement to the resident or resident's representative on 06/08/24.</p> <p>4. During an interview on 08/01/24, at 10:14 A.M., Licensed Practical Nurse (LPN) I said the following:</p> <p>-Nurses assess the resident with a change in condition and notify the physician or hospice;</p> <p>-Nurses print out the transfer document which includes a resident's diagnoses, medications, insurance information and give to the emergency medical staff;</p> <p>-The Social Service Director (SSD) is responsible for bed hold policy information.</p> <p>5. During an interview on 08/01/24, at 11:05 A.M., the SSD said the following:</p> <p>-Nurses inform administrative staff through a text message when a resident is transferred to the hospital;</p> <p>-She did not send a bed hold policy to the residents and/or responsible parties with the transfer;</p> <p>-She was unaware to send the bed hold policy when a resident is transferred out of the facility until she read the bed hold policy;</p> <p>-She did not have training on the bed hold policy when she took over social services.</p> <p>6. During an interview on 08/01/24, at 11:23 A.M., the Director of Nursing (DON) said staff did not send the bed hold policy to the residents and/or responsible parties upon transfer.</p> <p>7. During an interview on 08/01/24, at 11:23 A.M., the Administrator said staff did not send the bed hold policy to the residents and/or responsible parties upon transfer.</p> <p>8. During an interview on 08/01/24, at 11:23 A.M., the Director of Operations said staff should send the resident and/or responsible party the bed hold policy which informs them of the bed hold.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871</p> <p>Based on interview and record review, the facility failed to ensure all resident's drug regimens were free from unnecessary drugs when staff failed to provide adequate monitoring related to the administration of one resident's (Resident #148) diltiazem (used to treat high blood pressure and to control angina (chest pain) for (bradycardia-type of abnormal heart rhythm that occurs when the heart beats more slowly than normal) medication. A sample of 18 residents were reviewed in a facility with a census of 51.</p> <p>Review of the facility's policy titled Administering Medications, revised December 2012, showed the following:</p> <ul style="list-style-type: none"> -Medications shall be administered in a safe and timely manner, and as prescribed; -Medications must be administered in accordance with the orders, including any required time frame. <p>Review of the drug information insert for diltiazem, dated 08/02/24, showed diltiazem hydrochloride (HCL) decreases blood pressure. Diltiazem hydrochloride therapy and may result in symptomatic hypotension (low blood pressure).</p> <p>1. Review of Resident #'148's face sheet (admission data) showed the following:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses include cognitive communication deficit, bradycardia, and Parkinson's disease. <p>Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/19/24, showed resident had severely impaired cognitive skills.</p> <p>Review of the resident's care plan, initiated on 07/31/24, showed the following:</p> <ul style="list-style-type: none"> -At risk for adverse reactions of his/her medications. The resident received a variety of medications which may lead to adverse reactions; -Staff should administer the resident's medications as ordered; -The resident has altered cardiovascular (relating to the heart and blood vessels) status related to bradycardia and paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). <p>Review of the resident's July 2024 Physician Orders Sheet (POS) showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-An order, dated 07/17/24 , for diltiazem HCL oral tablet, 30 milligrams (mg), give one tablet by mouth (PO) three times (TID) a day related to bradycardia. Hold if systolic blood pressure reading (measured when the heart beats, when blood pressure is at its highest) is less than 110 millimeters of mercury (mmHg.)</p> <p>Review of the resident's July 2024 Medication Administration Record (MAR) showed the following:</p> <p>-An order, dated 07/17/24 , for diltiazem HCL oral tablet, 30 mg, give one tablet PO TID related to bradycardia. Hold if systolic blood pressure reading is less than 110 mmHg;</p> <p>-On 07/24/24, Certified Medication Technician (CMT) G documented the resident's blood pressure as 107/73 mmHg. CMT G documented administration of the diltiazem HCL. (The blood pressure was not within parameters to administer per the physician order.);</p> <p>-On 07/28/24, CMT G documented the resident's blood pressure as 106/90 mmHg. CMT G documented administration of the diltiazem HCL. (The blood pressure was not within parameters to administer per the physician order.);</p> <p>-On 07/30/24, CMT G documented the resident's blood pressure as 98/48 mmHg. CMT G documented administration of the diltiazem HCL. (The blood pressure was not within parameters to administer per the physician order.)</p> <p>During an interview on 08/01/24, at 10:14 A.M., Licensed Practical Nurse (LPN) I said the following:</p> <p>-Staff should find the medication, ensure the correct resident, check the medication and time, and administer as ordered;</p> <p>-Staff should document administration of a medication in the computer system;</p> <p>-The diltiazem medication parameters was to hold the medication if the resident's systolic blood pressure is not within the parameters;</p> <p>-The order was to hold the diltiazem if the systolic blood pressure is less than 110 mmHg;</p> <p>-Staff should not give the medication if the resident's systolic blood pressure was below 110 mmHg;</p> <p>-The physician ordered to hold the Diltiazem if below 110 mmHg due to it could drop the resident's blood pressure more.</p> <p>During an interview on 08/01/24, at approximately 10:30 A.M., CMT G said the following:</p> <p>-Staff should read the physician order before administering a medication;</p> <p>-Staff should read the directions if a medication order has specific parameters;</p> <p>-The resident's diltiazem order was to hold it if the systolic blood pressure is less than 110 mmHg;</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she should not have given the medication with the blood pressure was out of parameters.</p> <p>During an interview on 08/01/24, at 11:23 A.M., the Director of Nursing (DON) said the following:</p> <ul style="list-style-type: none"> -Staff should check a resident's blood pressure if the directions include parameters; -Staff should document the blood pressure; -The order was to hold the diltiazem if the systolic is less than 110 mmHg; -Reasons for the parameters for diltiazem was due to the resident's blood pressure could drop even more; -She expected staff to follow the physician orders; -Staff should not have administered diltiazem on the dates the resident's blood pressure was out of parameters. <p>During an interview on 08/01/24, at 11:23 A.M., the Administrator said she expected nursing staff to follow physician orders and ordered parameters for the resident's diltiazem.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48187</p> <p>Based on observation, record review, and interview, the facility staff failed to ensure all residents were free from significant medication errors when staff failed to prime (removing the air from the needle and cartridge that may collect during giving the resident too much or too little insulin) an insulin pen for one resident (Resident #30) prior to the administration of insulin. The facility had a census of 51.</p> <p>Review of the facility's policy titled Insulin Administration, revised September 2014, showed the policy did not address priming insulin pens before injection.</p> <p>Review of the facility's policy titled Administering Medications, revised December 2012 showed the policy did not address priming insulin pens before injection.</p> <p>Review of the manufacturer's insert regarding NovoLog (rapid acting insulin) Flex pens, last revised on March 2008, showed the pen should be primed before each injection. The pen should be primed by the following steps:</p> <ul style="list-style-type: none"> -Turn the dose selector to select two units; -Hold the pen with the needle pointing up; -Tap the cartridge gently with finger a few times to make any air bubbles collect at the top of the cartridge; -Keep the needle pointing upwards and press the push-button all the way in. The dose selector returns to zero; -A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times; -If a drop of insulin is not seen after six times, do not use the pen. <p>1. Review of Resident #30's face sheet (brief resident profile sheet) showed the following information:</p> <ul style="list-style-type: none"> -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a group of lung diseases making it difficult to breathe), high blood pressure, peripheral vascular disease (circulation disease caused by narrowed blood vessels), and diabetes. <p>Review of the resident's care plan, revised 06/01/24, showed the following information:</p> <ul style="list-style-type: none"> -At risk for decrease in nutritional needs related to his/her diabetes; <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff to perform accu-checks (blood glucose test) as ordered by the physician;</p> <p>-Administer medications for diabetes as ordered by the physician.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/27/24, showed the resident was cognitively intact.</p> <p>Review of the resident's physician order sheet (POS), current as of 08/01/24, showed the following orders:</p> <p>-An order, dated 06/12/24, to check blood glucose (sugar) before meals and at bedtime;</p> <p>-An order, dated 07/15/24, for Novolog U-100 Insulin aspart solution 100 unit/ml (unit of fluid volume), 4 units with meals subcutaneously (inject under the skin). Staff to hold if blood sugar glucose is less than 100 milligrams (mg)/deciliter (dL). Administer with meals, three times a day.</p> <p>Observation on 07/30/24, at 03:47 P.M., showed Licensed Practical Nurse (LPN) J went to the resident's room and checked the resident's blood sugar. The resident's blood sugar level measured 305 mg/dL. The LPN applied a new needle to the insulin pen. The LPN washed his/her hands, donned gloves, cleaned the resident's abdomen with an alcohol wipe, then administered the insulin to the resident's abdomen. The LPN pushed the knob, administered the dose, and held the pen in place for 5 seconds. The LPN did not prime the pen prior to administration of the insulin.</p> <p>During an interview on 07/30/24, at 3:55 P.M., LPN J said that he/she does not prime the pen prior to administering insulin. LPN J said that these pens come pre-dosed and pre-primed and are ready to go. Priming is not needed and that he/she never primes any of the pens.</p> <p>During an interview on 07/31/24, at 11:32 A.M., LPN I said that he/she always primes insulin pens with two units of insulin, prior to administering the insulin. LPN I said that all the nurses should know to prime the pen before each use.</p> <p>During an interview on 08/01/24, at 9:57 A.M., the Director of Nursing (DON) said that he/she was responsible for training the nursing staff how to properly administer insulin. He/she teaches the staff to complete hand hygiene, apply a new needle, prime with two units of insulin, cleanse the skin with an alcohol wipe, administer the insulin and then hold in place for 10 seconds. The DON said that the education is provided to nurses on hire and yearly. Staff should always prime all insulin pens with two units of insulin before each use. He/she expected all nursing staff to prime the pen every time.</p> <p>During an interview on 08/01/24, at 10:00 A.M., the Administrator said that he/she expected staff to administer insulin per physician orders and as they have been trained.</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>45176</p> <p>Based on observation, record review, and interview, the facility failed to keep food safe from potential contamination when staff stacked clean dishware inside one another instead of air drying, which could potentially contaminate food served from those items, when staff failed to keep dented cans separate from other canned goods, and when staff did not wear appropriate hair net correctly. The facility census was 51.</p> <p>1. Review of the 2022 Food Code, issued by the Food and Drug Administration (FDA), showed the following information:</p> <p>-After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food;</p> <p>-Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow.</p> <p>Review of the facility's policy titled Dishwashing Machine Operation, undated, showed staff to use clean, washed hands to pull out clean racks from dishwasher, and allow to air dry before putting dishes away for storage.</p> <p>Observations on 07/29/24, beginning at 9:48 A.M., showed two stacks of clear plastic cups, three stacked on top of one another, wet and trapping water between the items.</p> <p>Observations on 07/31/24, beginning at 8:49 A.M., showed 15 stacks of clear plastic cups, with three to five per stack, wet and stacked on top of one another trapping water between the items.</p> <p>During an interview on 08/01/24, at 9:00 A.M., Dietary Aide (DA) C said after dishes have been washed, they are to air dry on a rack. It would not be appropriate to stack wet dishes on top of one another.</p> <p>During an interview on 08/01/24, at 9:07 A.M., DA D said the following:</p> <p>-After dishes are washed, they are to let out until they're dry and then put them up;</p> <p>-He/she leaves the dishes on the cart to dry;</p> <p>-Dishes should not be put on top of one another wet.</p> <p>During an interview on 08/01/24, at 10:02 A.M., the Dietary Manager (DM) said after dishes are washed, they should be left on a rack to dry. Staff should not be stacking wet dishes on one another, that is not appropriate.</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 08/01/24, at 10:02 A.M., the Administrator said dishes should be dry when they're put away. It would not be appropriate to stack wet dishes.</p> <p>2. Review of the 2022 Food Code showed the following information:</p> <ul style="list-style-type: none"> -Depending on the circumstances, rusted and pitted or dented cans may also present a serious potential hazard; -Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food; -If the integrity of the packaging has been compromised, contaminants may find their way into the food. <p>Review of the facility's policy titled Food Storage, undated, showed dented cans are set aside in a separate labeled area of the storeroom to avoid using them and discarded according to vender procedure.</p> <p>Observations on 07/29/24, beginning at 9:48 A.M., showed one six pound can of apples dented and on the shelf with multiple other cans.</p> <p>Observations on 07/31/24, beginning at 8:49 A.M., showed one six pound can of apples dented on the shelf with multiple other cans.</p> <p>During an interview on 08/01/24, at 9:00 A.M., DA C said he/she did not use dented cans of food. He/she tells the DM when they receive a dented can and the DM takes the can of food.</p> <p>During an interview on 08/01/24, at 9:07 A.M., DA D said he/she did not use dented cans of food. He/she will tell the DM and the cans are put in another area in the back.</p> <p>During an interview on 08/01/24, at 10:02 A.M., the DM said the following:</p> <ul style="list-style-type: none"> -Staff are supposed to put dented cans in a milk crate in the back; -Staff should not be using food from dented cans; -He/she didn't know there was a dented can on the shelf. <p>During an interview on 08/01/24, at 10:02 A.M., the Administrator said the following:</p> <ul style="list-style-type: none"> -Staff should be setting dented cans aside, call the supplier, and return the dented can of food; -Food in dented cans should not be served to residents. <p>3. Review of the 2013 Food Code, issued by the Food and Drug Administration, showed the following:</p> <ul style="list-style-type: none"> -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>(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>Review of the facility's policy titled Staff Dress and Appearance, undated, showed dining staff working at a steam table or serving area in the dining room should have appropriate hair coverings.</p> <p>Observations on 07/29/24, beginning at 9:48 A.M., showed DA C in the kitchen, wearing a ball cap with five to six inches of hair hanging below the ball cap, with no hair net.</p> <p>Observations on 07/31/24, beginning at 11:01 A.M., showed DA C in the kitchen, wearing a ball cap with five to six inches of hair hanging below the ball cap, with no hair net. DA C prepared the food for residents on pureed diets.</p> <p>Observations on 07/31/24, beginning at 11:40 A.M., showed DA C in the dining room, wearing a ball cap with five to six inches of hair hanging below the ball cap, with no hair net, serving food out of the steam table.</p> <p>During an interview on 08/01/24, at 9:00 A.M., DA C said staff should be wearing hair nets when in the kitchen. He/she said if staff wear a hat, to cover their hair then they are not required to wear a hair net.</p> <p>During an interview on 08/01/24, at 9:07 A.M., DA D said staff are always supposed to wear hair nets when in the kitchen and around food. If staff wear a ball cap, he/she assumed they should still be wearing a hairnet.</p> <p>During an interview on 08/01/24, at 10:02 A.M., the DM said the following:</p> <ul style="list-style-type: none"> -Staff should be wearing hairnets as soon as they're in the kitchen; -If staff are wearing a ball cap, and hair is out of the ball cap, they should be wearing a hairnet; -If the hair is tucked under the ball cap, they wouldn't need a hair net. <p>During an interview on 08/01/24, at 10:02 A.M., the Administrator said the following:</p> <ul style="list-style-type: none"> -Anytime staff are in the kitchen or doing food service, they should be wearing hairnets; -If staff are wearing a ball cap, they should still be wearing hairnets, or the hair should be up under the ball cap. 		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>45176</p> <p>Based on observation, record review, and interview, the facility staff failed to ensure the facility was maintained in a sanitary and comfortable fashion when light fixtures in the kitchen and dining area had dead bugs present. The facility census was 51.</p> <p>Review showed the facility did not provide a policy regarding light fixtures.</p> <p>1. Observations on 07/29/24, beginning at 9:48 A.M., and on 07/31/24, beginning at 8:49 A.M., of the kitchen and dining areas showed the following:</p> <ul style="list-style-type: none"> -The light just before entering the kitchen had several dead bugs present; -The light above the refrigerator and freezer, towards the back of the kitchen, had several dead bugs present; -The two lights when entering the kitchen had several dead bugs present. <p>During an interview on 08/01/24, at 9:00 A.M., Dietary Aide (DA) C said the following:</p> <ul style="list-style-type: none"> -Ceiling lights are maintained by maintenance; -He/she doesn't know how often maintenance cleans or checks the lights; -He/she tells the Dietary Manager (DM) when he/she sees a problem with the lights. <p>During an interview on 08/01/24, at 9:07 A.M., DA D said the following:</p> <ul style="list-style-type: none"> -Maintenance takes care of cleaning inside of the ceiling lights; -Kitchen staff to let the DM know when there are kitchen issues, or write the issues in the book located next to the nurses' station. <p>During an interview on 08/01/24, at 10:02 A.M., the DM said the following:</p> <ul style="list-style-type: none"> -He/she expected kitchen staff to let the maintenance know of any issues in the kitchen; -Maintenance has a book to write kitchen issues in and they could also tell maintenance verbally; -Maintenance was responsible for maintaining the ceiling lights in the kitchen and dining room; -Maintenance did a walk through the kitchen and dining areas to see what needs to be repaired or cleaned; -He/she wasn't aware the lights had bugs in them. <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/01/24, at 10:40 A.M., the Maintenance Director said the following:</p> <ul style="list-style-type: none"> -He/she or the maintenance helper is responsible for cleaning the lights; -He/she doesn't expect kitchen staff to clean the lights; -He/she has a monthly checklist, and cleaning the ceiling lights in the dining room and kitchen are included on the list; -He/she also walked around and checked the ceiling lights; -He/she wasn't aware of the bugs inside of the lights in the kitchen or dining room; -He/she would expect the lights to be free of bugs. <p>During an interview on 08/01/24, at 10:02 A.M., the Administrator said maintenance is responsible for cleaning the ceiling lights. Kitchen staff should be writing down kitchen and dining room needs in the requisition book.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176</p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to control the gnat population, when multiple gnats were present in one room, with two residents (Residents #2 and Resident #37) out of a total sample of 18. The facility census was 51.</p> <p>Review of the facility policy titled Pest Control, revised May 2008, showed the following:</p> <ul style="list-style-type: none"> -The facility shall maintain an effective pest control program; -This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. <p>1. Review of Resident #2's face sheet (admission data) showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's annual assessment sheet (MDS - a federally-mandated assessment form completed by facility staff), dated 06/03/24, showed the following:</p> <ul style="list-style-type: none"> -No cognitive impairment; -Resident required set up with personal hygiene. <p>2. Review of Resident #37's face sheet showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's quarterly MDS, dated [DATE], showed the following:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Set up or supervision with daily living skills. <p>3. Observation and interview on 07/29/24, at 4:40 P.M., in Resident #2 and #37's room, showed the following:</p> <ul style="list-style-type: none"> -Resident #2 said Resident #37 leaves food and cups in the room that caused the room to have gnats; -Resident #2 said he/she had asked his/her son to bring some fly traps; -Two cups and a bowl with some type of food sat by the sink; -Four gnats flew around the sink, two gnats sat on the cups, and at least four gnats sat on the ceiling above the sink. <p>Observation on 07/30/24, at 9:49 A.M., of Resident #2 and #37's room, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Four gnats flew around the sink;</p> <p>-One partially eaten banana lay on Resident #37's bedside table and five gnats flew on and around the banana.</p> <p>Observation on 07/31/24, at 8:32 A.M., of Resident #2 and #37's room, showed the following:</p> <p>-Resident #37 came into his/her room to lay down;</p> <p>-Several gnats flew around the sink. There was an almost empty cup of chocolate milk that had four gnats on and around the cup.</p> <p>Observation on 07/31/24, at 2:18 P.M. and 4:39 P.M., of Resident #2 and #37's room, showed the following:</p> <p>-Food in the sink and two cups that had some milk in them;</p> <p>-Three flies flew around the sink. Several gnats flew around or on the ceiling and gnats sat on the cups;</p> <p>-Resident #37 had several cups on his/her bedside table. there were three gnats flying around the table.</p> <p>Observation on 08/01/24, at 8:20 A.M., of Resident #2 and #37's room, showed the following:</p> <p>-Resident #37 lay in his/her bed with his/her eyes closed;</p> <p>-Three large cups on the bedside table and two packs of opened candy sat on the resident's bed;</p> <p>-Several gnats and flies flew around the table and bed.</p> <p>Observations in on 08/01/24, at 10:56 A.M., 1:11 P.M., and 2:05 P.M., of Resident #2 and #37's room, showed the Maintenance Director in the resident's room tested the resident's water temperature while several gnats flew around the resident's sink and the ceiling above the sink.</p> <p>During an interview on 08/01/24, at 9:15 A.M., Certified Nurse Aide (CNA) E said the following:</p> <p>-He/she had seen gnats, usually around the resident's sink, but they're usually gone the next day;</p> <p>-He/she has seen them in Resident #37's room;</p> <p>-Resident #37 hoards food and cups in his/her room;</p> <p>-He/she tried to pick up the food and cups at least one time per shift;</p> <p>-He/she reported seeing the gnats in resident's room to the Maintenance Director.</p> <p>During an interview on 08/01/24, at 9:30 A.M., Housekeeper A, said the following:</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265577	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Marshfield Care Center for Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 800 South White Oak Marshfield, MO 65706	

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she had seen the gnats in residents' rooms, especially in Resident #37's room around his/her sink;</p> <p>-Resident #37 likes to keep a lot of food and drinks in his/her room and sometimes he/she finds half eaten bananas;</p> <p>-He/she has told the Maintenance Director about the gnats in Resident #37's room;</p> <p>-A pest company sprays, but he/she doesn't know how often.</p> <p>During an interview on 08/01/24, at 10:20 A.M., Certified Medication Technician (CMT) G, said the following:</p> <p>-He/she has seen gnats in a few of the residents' rooms;</p> <p>-He/she sees some in Resident #37's room;</p> <p>-Housekeeping usually takes care of them and there is a pest control company that sprays;</p> <p>-Staff usually pick up any cups and dishes not being used in resident rooms routinely.</p> <p>During an interview on 08/01/24, at 10:30 A.M., Registered Nurse (RN) H, said the following:</p> <p>-There have been complaints from residents about gnats;</p> <p>-The residents have been complaining less because housekeeping has been cleaning specific rooms;</p> <p>-Resident #37 likes to keep fruit in his/ her room;</p> <p>-Staff have been trying to make sure things are picked up in the resident's rooms and they've been spraying. They also have a pest control company;</p> <p>-He/she would tell the Maintenance Director if there was issues with gnats.</p> <p>During an interview on 08/01/24, at 10:40 A.M., the Maintenance Director said the following:</p> <p>-He/she didn't know there was an issue with gnats until last week;</p> <p>-He/she was told there were gnats on C hall so the facility bought some plug in devices to put in a few rooms;</p> <p>-He/she has seen some in Resident #37's room, but since putting the electronic devices in some other rooms it has drastically reduced the gnats;</p> <p>-He/she believed the source was due to some bananas that he/she threw way back behind the facility and this pulled the gnats to the facility doors;</p> <p>-He/she has not found any cups of bowls of food in residents' rooms;</p> <p>(continued on next page)</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/she has seen food be put down sinks and he/she has needed to clean out the drains;</p> <p>-He/she has told housekeeping staff to run the sinks for five minutes when they're in the rooms cleaning.</p> <p>Observation and interview on 08/01/24, at 12:17 P.M., in Resident #2 and #37's room, with the Administrator, showed the following:</p> <p>-Multiple gnats flew on Resident #37's bedside table and the resident's cup on the bedside table;</p> <p>-Multiple gnats sat on the ceiling and wall beside the sink area in the resident's room;</p> <p>-Multiple gnats buzzed around and sat on the three cups beside the resident's sink;</p> <p>-The Administrator said she was not aware of the gnats in the resident's room;</p> <p>-Staff should tidy up the resident's room and take out any cups or food;</p> <p>-Staff should notify administration staff of the gnats in the resident's room;</p> <p>-The facility has placed some plug in devices in other resident rooms around the room.</p> <p>During an interview on 08/01/24, at 3:06 P.M., the Administrator said the following:</p> <p>-She expected staff to report to the maintenance or administrative staff when there are gnats;</p> <p>-She was not aware of the gnats in the resident's room and facility staff were focused on other rooms on the same hall which had gnats.</p> <p>MO00237455</p> <p>34871</p>