

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265589	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  St Peters Rehab and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 230 Spencer Road Saint Peters, MO 63376	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0880</p> <p>Level of Harm - 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** 34003</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff performed appropriate hand hygiene and changed gloves during the provision of care for one resident (Residents #2), and failed to follow the facility policy for Enhanced Barrier Precautions (EBP) for four residents (Residents #1, #2, #3, and #4), in a review of nine sampled residents. Staff failed to utilize Personal Protective Equipment (PPE) while providing high-contact care activities or wound care. The facility had identified 16 residents with wounds, six residents with indwelling catheters (a sterile tube inserted into the bladder to drain the bladder of urine) and three residents receiving Enteral tube feedings (a tube placed in the stomach to provide nutrition). The facility census was 81.</p> <p>Review of the facility policy for Perineal Care with a revision date of 10/22 showed the following:</p> <ul style="list-style-type: none"> <li>-Wash hands, put on gloves, provide perineal care to the resident, remove wet linen, place dry linens or briefs underneath the resident, reposition the resident;</li> <li>-Remove gloves and wash hands or use alcohol-based hand sanitizer. Do not touch anything with gloves after the procedure;</li> <li>-Put on clean gloves;</li> <li>-Clean and return any equipment to its proper place;</li> <li>-Place soiled linen in proper container;</li> <li>-Remove gloves;</li> <li>-Wash hands.</li> </ul> <p>Review of the facility policy for Hand Hygiene with a revision date of 10/22 showed the following:</p> <ul style="list-style-type: none"> <li>-The facility considers hand hygiene the primary means to prevent the spread of infections;</li> <li>-Facility staff follow the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors;</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Facility staff must perform hand hygiene procedures in the following circumstances: before eating, after using the bathroom, when soiled with visible dirt or debris; contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, intact skin soiled with blood or other body fluids, wound drainage and soiled dressings after contact with intact or non-intact skin, clothing and environmental surfaces of residents with active diarrhea even if gloves are worn, before and after food preparations and before and after assisting residents with dining if direct contact with food is anticipated or occurs and in between glove changes;</p> <p>-Hand hygiene is always the final step after removing and disposing of person protective equipment.</p> <p>Review of the facility policy for Standard and Enhanced Precautions with a revision date of 7/23 showed the following:</p> <p>-Standard Precautions are used in the care of residents regardless of their diagnoses or suspected or confirmed infections status. Standard Precautions presume that blood, body fluids, secretions and excretions (except sweat), non intact skin and mucous membranes may contain transmissible infection agents;</p> <p>-Standard Precautions apply to the care of all residents regardless of suspected or confirmed presence of infectious diseases;</p> <p>-Standard Precautions include hand hygiene, gloves, masks and eyewear, gowns;</p> <p>-Enhanced standard precautions will be implemented for residents with a known Multi Drug Resistance Organism (MDRO) and who are at high-risk for colonization (refers to the presence of microorganisms on or within a person's body, where they are multiplying and growing, but without causing any noticeable symptoms or disease) and transmission;</p> <p>-Resident characteristics that are associated with a high-risk of MDRO colonization and transmission include presence of indwelling devices (e.g. urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters); wounds, or presence of pressure ulcer (unhealed; functional disability and total dependence on others for assistance with activities of daily living.</p> <p>1. Review of Resident #1 undated face sheet showed the resident with diagnoses of multiple sclerosis (is a chronic, autoimmune disease that affects the central nervous system (brain and spinal cord).</p> <p>Review of the resident's nurses progress notes dated 2/5/25 showed the resident admitted to the hospital due to vomiting.</p> <p>Review of the resident's nurses progress notes dated 2/10/25, showed the resident readmitted to the facility with diagnosis of Influenza A and open areas on both buttocks. Consult outside wound care agency for treatment.</p> <p>Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 2/13/25 showed the following:</p> <p>-Dependent upon staff for toileting and personal hygiene;</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>-Incontinent of bowel and bladder.</p> <p>Review of the resident's facility wound report dated 2/25/25 showed the resident had an open area to the right and left buttock.</p> <p>Observation on 2/25/25 from 9:00 A.M. to 4:00 P.M., showed no sign on the resident's door posted for EBP or directing staff to wear personal protective equipment (PPE) when providing care to the resident.</p> <p>Observation on 2/27/25 at 7:24 A.M. showed the following:</p> <ul style="list-style-type: none"> <li>-No EBP sign posted on the resident's door to inform staff the resident was on EBP precautions and what PPE to wear;</li> <li>-Certified Nurse Aide (CNA) B and Nurse Aide (NA) C entered the resident's room without wearing gowns to provide incontinent care to the resident;</li> <li>-The resident had been incontinent of feces;</li> <li>-CNA B and NA C provided incontinent care, then gathered the dirty linens and took out of the room to the soiled linen barrel;</li> <li>CNA B and NA C did not remove their gloves and wash hands prior to leaving the resident's room;</li> <li>-CNA B and NA C returned to the room and washed hands.</li> </ul> <p>Observation on 2/27/25 at 9:00 A.M., showed the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) place a sign on the door to Resident #1's room that showed the following:</p> <ul style="list-style-type: none"> <li>-STOP Enhanced Barrier Precautions Everyone Must: clean their hands, including before entering and when leaving the room;</li> <li>-Providers and staff must also wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering transferring, changing linens, providing hygiene, changing briefs or assisting with toileting; device care of use: central line, urinary catheter, feeding tube, tracheostomy; wound care - any skin opening requiring a dressing;</li> <li>-Do not wear the same gown and gloves for the care of more than one person.</li> </ul> <p>During an interview on 2/27/25 at 9:30 A.M. CNA B said the following:</p> <ul style="list-style-type: none"> <li>-He/She was not aware that Resident #1 was on EBP;</li> <li>-He/She was told after providing care the resident was on EBP and gowns should be worn when providing care;</li> <li>-The sign was not on the door when he/she provided care.</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>During an interview on 2/27/25 at 10:00 A.M. ADON/IP said the following:</p> <ul style="list-style-type: none"> <li>-He/She was responsible for the facility's infection control program;</li> <li>-Resident #1 should have had a sign on the door alerting staff to the EBP;</li> <li>-Resident #1 was on EBP due to wounds.</li> </ul> <p>2. Review of Resident #2's quarterly MDS dated [DATE] showed the following:</p> <ul style="list-style-type: none"> <li>-Diagnoses of stroke and aphasia (inability to speak);</li> <li>-Receives enteral feedings (a tube placed in the stomach to receive nutrition) for all nutritional needs.</li> </ul> <p>Observation on 2/25/25 from 9:00 A.M. to 4:00 P.M., showed no sign posted for EBP or directing staff to wear personal protective equipment (PPE) when providing care to the resident.</p> <p>Observation on 2/27/25 at 8:00 A.M. showed no sign posted for EBP or directing staff to wear personal protective equipment (PPE) when providing care to the resident.</p> <p>Observation on 2/27/25 at 8:17 A.M. showed the following:</p> <ul style="list-style-type: none"> <li>-CNA D enter the resident's room; CNA D did not don a gown, did apply gloves and told the resident he/she needed to change him/her;</li> <li>-CNA D removed the resident's urine saturated brief, placed the brief on the floor, and removed one wipe from a package and with a back and forth motion wiped the resident's genitals. CNA D then rolled the resident to his/her left side, obtained another wipe from the package and with a back and forth motion wiped the residents buttocks;</li> <li>-CNA D removed a urine soaked from under the resident and threw the pad on the floor, placed a clean pad under the resident and then placed a clean brief under the resident. Without removing soiled gloves and performing hand hygiene before applying a clean pair of gloves, CNA D took a tube of skin barrier ointment out of the nightstand drawer and with one hand squeezed some ointment on the other hand and rubbed the ointment on the resident's buttocks. CNA D then fastened the brief around the resident;</li> <li>-With the same soiled gloves, CNA D removed the resident's gown that was wet with urine, threw the gown on the floor, put a clean gown on the resident, removed the top sheet and threw it on the floor, then put a clean top sheet on the resident;</li> <li>-With the same soiled gloves CNA D picked up the dirty linen off the floor and put the dirty linen in a bag;</li> <li>-With a towel and wearing the same soiled gloves, he/she wiped the over the bed table off, opened the door using the door handle, took the dirty linen down the hall to a linen barrel;</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>-Sensitivity report (a test that will show what bacteria is in the urine) showed greater than 100,000 CFU/ml (shows the amount of bacteria grown in the urine) of Proteus Mirabilis (a bacteria that can cause urinary tract infections, and can be transmitted by coming into contact with contaminated objects like catheters.</p> <p>Observation on 2/27/25 at 11:50 A.M. showed the following:</p> <p>-The resident sat in a wheelchair in the main dining room with an indwelling catheter. The indwelling catheter bag and tubing touched the floor, there was dark yellow urine with sediment in the tubing;</p> <p>-The resident's arms and face were bright red and he/she complained of itching. Registered Nurse (RN) E pushed the resident to his/her room with the catheter bag touching the floor and the tubing to the catheter dragging on the floor;</p> <p>-An EBP sign was on the door to the resident's room alerting staff the resident was on EBP precautions;</p> <p>-RN E put on a pair of gloves and obtained a bottle of lotion, placed a large amount of lotion on his/her gloved hand and began to spread the lotion on the resident's arms and legs. When finished, RN E removed his/her gloves, washed his/her hands and pushed the resident back to the dining room.</p> <p>During an interview on 2/27/25 at 11:55 A.M. RN E said the following:</p> <p>-The resident was on EBP due to having a wound, an indwelling catheter and a current UTI;</p> <p>-He/She should have put on a gown along with the gloves before putting lotion on the resident.</p> <p>During an interview on 2/27/25 at 12:00 P.M. the ADON/IP said staff should have followed the EBP guidelines for the resident as he/she was at high risk for infections.</p> <p>4. Review of Resident #4's face sheet showed the resident admitted to the facility on [DATE].</p> <p>Review of the resident's comprehensive MDS dated [DATE] showed the following:</p> <p>-Dependent upon staff for ADLs;</p> <p>-Has an indwelling catheter and third degree burns (a serious wound that damages all three layers of the skin);</p> <p>-Diagnoses of cerebral palsy (is a group of disorders that affect movement, balance, and posture. It is caused by damage to the developing brain before, during, or shortly after birth. This damage can lead to permanent changes in the brain that interfere with the brain's ability to control muscle movement).</p> <p>Observation on 2/25/25 at 1:00 P.M. showed:</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 resident laid in the bed with an indwelling catheter bag hanging on the side of the bed, there was dark yellow urine in the tubing and bag with no sign posted for EBP;</p> <p>-Several staff entered the resident's room to reposition the resident and wore no PPE.</p> <p>Observation on 2/27/25 at 9:00 A.M. showed the ADON/IP placed an EBP sign on the door. The ADON/IP said the resident should have been on EBP precautions due to the indwelling catheter and the third degree burns.</p> <p>During an interview on 2/27/25 at 11:30 A.M. the ADON/IP said the following:</p> <p>-Residents who have infections, indwelling catheters, enteral tube feedings, and wounds should be placed on EBP;</p> <p>-He/She is a little behind identifying who was on EBP, but the nurses should also identify and place a resident on EBP when the resident met criteria for EBP;</p> <p>-The facility has 15 residents with pressure ulcers, eight residents with indwelling catheters and three residents with enteral feeding;</p> <p>-In January there was five residents with wound infections and five residents with urinary tract infections;</p> <p>-As of February 18th there was three urinary tract infections documented on the Infection Control log.</p> <p>During an interview on 2/27/25 at 2:00 P.M. the Director of Nursing said the following:</p> <p>-She would expect staff to follow their policy for hand washing when providing care;</p> <p>-Nursing staff was aware prior to admission if a resident has an indwelling catheter, an enteral tube feeding, a wound or an infection that meets the criteria for EBP. She would expect the nurses to put EBP precautions in place at the time of admission, or when the resident meets the criteria. She would expect all staff to follow the facility policy for EBP.</p> <p>During an interview on 2/27/25 at 2:00 P.M. the Administrator said she would expect staff to follow their policy for hand washing and EBP.</p> <p>MO250092</p>		