STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265590	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor	200 South St Paris, MO 65275

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow current infection control standards for six residents (Residents #87, #4, #75, #1, #53, and #18), in a review of 20 sampled residents, when staff failed to follow enhanced barrier precautions (EBP, precautions for use during high-contact resident care activities for residents infected with a multi drug resistant organism (MDRO) or any resident who has a chronic wound and/or indwelling medical device) to prevent infection while providing personal care, failed to ensure urinary catheter (a flexible tube inserted into the bladder) tubing was not on the floor, failed to ensure oxygen tubing was properly stored when not in use, and failed to follow the facility's policy and procedure for handwashing, gloving, handling of linens and respiratory therapy. The facility census was 82. Review of the facility's undated policy, Handwashing/Hand Hygiene, showed the following:-This facility considers hand hygiene the primary means to prevent the spread of infections;-All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors;-Wash hands with soap and water when hands are visibly soiled, -Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively,soap and water before and after direct contact with residents, before performing any non-surgical invasive procedures, before and after handling an invasive device (e.g., urinary catheters), before handling clean or soiled dressings, gauze pads, etc., before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with blood or bodily fluids, after handling used dressings, contaminated equipment, etc., after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, after removing gloves, before and after entering isolation precaution settings, hand hygiene is the final step after removing and disposing of personal protective equipment; -The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections; Review of the facility's EBP Policy, last reviewed/revised 02/2026, showed the following:-Purpose: to decrease transmission of CDC-targeted and epidemiologically important multidrug resistant organisms when contact precautions do not apply;-EBP will be required on residents who have an indwelling catheter (suprapubic or inserted), have a wound requiring a dressing with the exception of skin tears requiring an adhesive bandage (Band-aid);-EBP will be required while performing the following high-contact resident care activities; dressing, bathing/showering, transferring, -Providing hygiene (peri-care); changing linens, changing briefs or assisting with toileting, device care or use, urinary catheter, wound care and/or any skin opening requiring a dressing, when anticipating close physical contact while assisting with transfers, mobility, etc., -EBP includes wearing gloves and gowns. Gloves will be stocked in the resident room in the glove holders, and gowns will be stocked in the resident's nightstand. Review of the Centers for Disease Control and Prevention (CDC), Definition and Scope of Enhanced Barrier Precautions, dated 6/28/24, showed standard precautions still apply while using Enhanced Barrier Precautions. If splashes and sprays are anticipated during the high-contact activity, face protection should be used in addition to gown and gloves. Review of the CDC's Best Practices for Environmental Cleaning in Global Healthcare Facilities (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Limited Resources, Appendix D, Linen and laundry management, dated 3/19/24, showed the following:-Never carry soiled linen against the body. Always place it in the designated container;-Place soiled linen into a clearly labeled container (e.g., bag, bucket) in the resident care area. Do not transport soiled linen by hand outside the specific resident care area from where it was removed. Review of the facility policy, Respiratory Therapy, dated 11/2022, showed the following:-The facility will ensure each resident receives necessary respiratory care and services that is in accordance with professional standards of practice;-Oxygen tubing will be kept in Ziplock bags when not in use. Review of the facility's undated clean dressing change checkoff showed the following:-Remove dirty dressing and place in trash can;-Remove gloves and perform hand hygiene;-Clean wound with gauze and cleaning solution using a single outward strokes and separate gauze for each cleansing wipe;-Use dry gauze to pat the wound;-Apply clean dressing as ordered. 1. Review of Resident #87's undated face sheet showed the following:-Diagnoses of bacterial pneumonia (a serious lung infection caused by bacteria that infect the air sacs leading to inflammation and accumulation of fluid or pus), sepsis (infection of the blood) Influenza A with other respiratory symptoms, acute respiratory failure (a life-threatening, sudden-onset condition where the lungs cannot adequately transfer oxygen to the blood or remove carbon dioxide) with hypoxia (when the tissues in the body do not receive enough oxygen). Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 02/24/26, showed the resident had a urinary catheter. Review of the resident's care plan, updated 03/10/26, showed the following:-Impaired gas exchanged related to infection in the lungs;-Required a urinary catheter related to chronic kidney disease and urinary retention;-Do not allow tubing or any part of the drainage system to touch the floor;-Required EBP related to indwelling urinary catheter;-PPE will be readily available in the room;-Signs will be placed in the room to alert staff of EBP;-Staff will wear gown and gloves when providing personal cares, changing linens, and transferring resident when not in a public setting.-The care plan was not specific about the PPE requirement when emptying the catheter;-The care plan did not address respiratory equipment care. Review of the resident's April 2026 physician order sheet, showed the following:-May have urinary catheter for urinary retention;-Oxygen at 2 liters (L) per minute by nasal cannula as needed. Observation on 04/06/26 at 2:02 P.M. showed the following:-An EBP sign was posted on the resident's door, and PPE was available in the room; -An oxygen concentrator was at the resident's bedside and was running. The nasal cannula tubing and the nasal cannula, attached to the oxygen concentrator, lay directly on the floor. Observation on 04/07/26 at 9:26 A.M. and 1:29 P.M. showed the following:-The resident lay in bed;-An oxygen concentrator was at the resident's bedside and was running. The nasal cannula, attached to the oxygen concentrator, lay directly on the floor. Observation on 04/08/26 at 6:31 A.M. showed the following:-Certified Nurse Assistant (CNA) D put on gloves and emptied urine from the resident's catheter bag into the toilet. He/She did not wear a gown or face protection; -CNA D removed his/her gloves, did not perform hand hygiene, and put on new gloves. CNA D did not put on a gown; -CNA D assisted the resident to change his/her pants; -CNA D dropped the resident's urinary catheter bag on the floor multiple times while assisting the resident to change his/her pants; -CNA D removed the oxygen cannula from the resident's nose and placed it on the bed; he/she did not put the nasal cannula into a bag;-CNA D placed the resident's catheter bag directly on the floor and assisted the resident to stand while he/she pulled up the resident's pants;-The resident sat in the wheelchair;-CNA D hooked the resident's catheter bag under the resident's wheelchair. The catheter tubing touched the ground; -CNA D removed his/her gloves, did not perform hand hygiene, did not put on gloves, and assisted the resident to change his/her shirt;-CNA D put the foot pedals on the resident's wheelchair and handed the resident his/her glasses;-CNA D picked up the resident's dentures that sat directly on the bedside table without a barrier, rinsed the dentures in the sink, and handed them to the resident who put them in his/her mouth;-CNA D did not perform any hand hygiene;-CNA D shut off the oxygen concentrator and left the nasal cannula tubing lying directly on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's bed; -CNA D pushed the resident in his/her wheelchair to the dining room. The catheter tubing dragged on the floor down the hallway, approximately 300 feet. During an interview on 04/08/26 at 7:26 A.M., CNA D said the following:-The resident was on EBP due to having a urinary catheter;-He/She should have worn a gown when emptying the resident's catheter and when helping the resident get dressed; -He/She should wash his/her hands upon entering the room, between glove changes and upon finishing or exiting the room; -He/She should have performed hand hygiene upon entering the room, after emptying the catheter and when he/she changed his/her gloves; -He/She did not realize he/she placed the catheter bag directly on the ground during cares and did not realize the catheter tubing touched the ground after connecting it under the wheelchair;-He/She knew the catheter bag and tubing should never touch the ground due to infection control purposes;-He/She did not remember placing the resident's oxygen tubing on the bed. Usually, he/she wrapped the tubing and placed it on top of the oxygen concentrator, making sure to keep the nasal cannula off the ground;-There was not always a bag to store the oxygen tubing. If there was one, he/she put the tubing in it. Otherwise, he/she just hang the tubing, making sure to keep the nasal cannula off the ground. Observation on 04/08/25 at 6:49 A.M. showed the following:-Staff pushed the resident in the wheelchair down the hallway; -The resident's urinary catheter tubing dragged on the floor; -There was cloudy urine in the urinary catheter tubing. Observation on 04/08/25 at 6:56 A.M. showed the following:-The resident sat in a wheelchair in the dining room;-His/Her urinary catheter tubing sat directly on the floor under the wheelchair; -There was cloudy yellow urine in the urinary catheter tubing. Observation on 04/08/26 at 7:04 A.M. showed the resident's oxygen nasal cannula lay directly on the bed. Observation on 04/08/25 at 7:30 A.M. and 7:52 A.M., showed the following:-The resident sat in a wheelchair in the dining room;-His/Her urinary catheter tubing sat directly on the floor under the wheelchair; -There was cloudy yellow urine in the catheter tubing. Observation on 04/08/26 at 12:44 P.M. showed the resident was not in his/her room. The oxygen concentrator was turned on and the oxygen tubing lay across the bedside table. The oxygen tubing was not stored in a bag. Observation on 04/09/26 at 8:48 A.M. and 9:25 A.M. showed the resident was not in his/her room. The oxygen concentrator was turned on and the oxygen tubing lay on the floor. During an interview on 04/09/26 at 9:35 A.M., Licensed Practical Nurse (LPN) E said staff should store oxygen tubing in a bag when not in use. 2. Review of Resident #4's care plan, last reviewed/revised 02/17/26, showed the following:-The resident required a supra pubic urinary catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine) related to stroke;-Do not allow urinary catheter tubing or any part of the drainage system to touch the floor;-The resident required EBP during high contact resident care activities related to the presence of indwelling device(s), (urinary catheter);-The resident had a urinary catheter;-Ensure items for following enhanced barrier precautions are in place (gloves, gown, alcoholbased hand rub, face shield, signage, trash receptacle, soap and water);-Hand hygiene utilizing alcohol-based rub or soap and water before and after cares;-Place enhanced barrier precautions notification/signage near the resident's doorway to alert staff/visitors of precaution;-Utilize PPE (gowns, gloves, face shield) as indicated during high contact resident care activities (dressing, bathing/showering, transferring, performing hygiene, soiled linen changes, brief/pull-up changes, toileting assistance, device care, wound care). Review of the resident's comprehensive MDS, dated [DATE], showed the following:-He/She was severely cognitively impaired;-He/She had a urinary catheter;-He/She was dependent on staff for toileting hygiene, upper and lower body dressing, to roll left and right,sit to lying, lying to sitting on bedside and chair to bed to chair transfers. Review of the resident's April 2026 physician orders showed the resident had an order for a urinary catheter. Observation on 04/08/25 at 6:22 A.M., showed the following:-The resident lay in bed with the bed in the low position;-The resident's urinary catheter tubing lay directly on the fall mat next to the resident's bed; -The urine in the catheter tubing was dark yellow (normal urine color is clear, pale yellow to amber in color). During an interview on 04/08/26 at 6:28 A.M., CNA C said catheter tubing should never touch the floor. If catheter tubing sat (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the floor, it could increase the resident's risk of infection. Observation on 04/08/26 at 6:55 A.M., showed LPN E entered the resident's room and performed a blood sugar finger stick on the resident and administered insulin. He/She stood on the right side of the resident's bed. The resident's catheter tubing lay directly on the fall mat beside the resident's bed. LPN E did not readjust the resident's catheter tubing. During an interview on 04/08/26 at 7:46 A.M. and 04/09/26 at 9:35 A.M., LPN E said the following:-Catheter tubing should not touch the floor;-When he/she entered the resident's room, he/she did not notice the catheter tubing lay directly on the fall mat;-Catheter bags and tubing should never touch or drag the ground, due to the increased risk of infection. Observation on 04/08/26 at 7:04 A.M. showed the resident's catheter tubing lay directly on the fall mat on the right side of the resident's bed. Observation on 04/08/26 at 7:09 A.M. showed the following:-CNA D entered the resident's room, did not perform hand hygiene, and put on gloves and gown;-The gowns were in a bag on the back of the resident's door, and the gloves were located by the sink. There were no face protection located near the resident's door or in his/her room;-CNA D emptied urine from the resident's catheter bag into the toilet. CNA D did not wear face protection;-CNA D removed his/her gloves, and without performing hand hygiene, put on new gloves; -CNA D cleaned the resident's peri area;-While wearing the same gloves he/she wore to provide incontinence care, CNA D opened the resident's bedside drawer, removed a tube of barrier cream, handed the barrier cream to CNA C, and CNA C applied a small amount from the tube onto CNA D's glove;-CNA D applied the barrier cream to the resident's peri area; -CNA D removed his/her gloves, did not perform hand hygiene, and put on new gloves;-CNA D performed additional peri care, did not remove his/her gloves, applied the Hoyer sling (device used for a mechanical lift) to the Hoyer lift (mechanical lift device), used the Hoyer lift control to lift the resident out of bed, and assisted the resident to put on a shirt; -CNA D removed his/her gloves, did not perform hand hygiene, and left the resident's room. During an interview on 04/08/26 at 7:35 A.M., CNA D said he/she should have washed his/her hands when he/she entered the resident's room and before he/she put on gloves. He/She should not touch any clean surfaces with dirty gloves. He/She did not change his/her gloves after performing peri care, and he/she touched the resident's clothes with dirty gloves. He/She did not wash his/her hands with soap and water or use hand sanitizer when he/she changed his/her gloves. He/She should have washed his/her hands with soap and water or used hand sanitizer during the resident's incontinence care. During an interview on 04/09/26 at 1:16 P.M., the Director of Nursing (DON) said catheter tubing should not lay on the floor. 3. Review of Resident #75's care plan, last reviewed/revised 01/16/26, showed the following:-He/She was incontinent of bowel and bladder; -Provide incontinence care after each incontinent episode. Review of the resident's quarterly MDS, dated [DATE], showed the following:-He/She was always incontinent of bowel and bladder;-He/She was dependent on staff for toileting hygiene. Observation on 04/06/26 at 11:37 A.M. showed the following:-Certified Nurse Assistant (CNA) G brought the sit-to-stand lift (a mechanical lift used to assist from a sitting to a standing position) into the resident's room;-CNA G washed his/her hands and put on gloves;-CNA G pulled down the resident's pants, removed the resident's urine soiled incontinence brief, and wiped feces from the resident's buttocks;-Without removing his/her gloves, CNA G applied a clean incontinence brief to the resident, pulled up the resident's pants, pulled down the resident's shirt, touched the controls of the sit-to-stand lift and lowered the resident into his/her wheelchair, and handed the resident his/her tablet and headphone while wearing the same gloves he/she wore to provide incontinence care;-CNA G removed his/her gloves, and without washing his/her hands, pushed the resident out of his/her room in his/her wheelchair. During an interview on 04/08/26 12:45 P.M., CNA G said the following:-He/She should remove his/her gloves when they were soiled and wash his/her hands with soap and water;-He/She did not take off his/her soiled gloves and wash his/her hands before touching clean surfaces;-He/She should not touch any clean surfaces with soiled gloves;-He/She forgot to remove his/her soiled gloves and wash his/her hands with soap and water before touching clean surfaces. During an interview on 04/09/26 at 10:01 A.M., the Director or (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing said staff should not touch clean surfaces with contaminated gloves/hands. 4. Review of Resident #1's undated face sheet showed he/she had a diagnosis of pneumonia (infection and inflammation of the lung). Review of the resident's admission MDS, dated [DATE], showed continuous oxygen was used on admission and while a resident. Review of the resident's April 2026 physician order sheet showed an order for continuous oxygen at 3 liters (L)/minute via nasal cannula. Review of the resident's care plan, updated 02/18/26, showed no documentation regarding continuous oxygen use or care of respiratory equipment. Observation on 04/07/26 at 9:01 A.M. showed the following:-A portable oxygen tank on the resident's wheelchair. The oxygen tubing was coiled up and hung over the oxygen regulator. The nasal cannula was not in a bag;-The resident was not wearing oxygen. Observation on 04/07/26 at 12:07 P.M. showed the resident sat in his/her wheelchair in the dining room. He/She was not wearing oxygen. A portable tank was on the back of his/her wheelchair. The oxygen tubing hung freely from the tank and was not stored in a bag. Observation on 04/08/26 at 6:26 A.M. showed the resident sat in his/her wheelchair in his/her room. He/She was not wearing oxygen. The portable oxygen tank was on the back of the wheelchair and the tubing was not in a bag. Observation on 04/08/26 at 7:14 A.M. showed the resident sat in his/her wheelchair in the dining room. He/She was not wearing oxygen. A portable oxygen tank was on the back of his/her wheelchair and the oxygen tubing was not in a bag. Observation on 04/09/26 at 8:42 A.M. showed the resident sat in his/her wheelchair in his/her room. He/She was not wearing oxygen. A portable oxygen tank was on the back of his/her wheelchair. The oxygen tubing was coiled up and hung over the regulator and was not in a bag. Observation on 04/09/26 at 11:46 A.M. showed the resident sat in his/her wheelchair in the dining room. He/She was not wearing oxygen. The portable tank was on the back of the wheelchair and the oxygen tubing was not in a bag. During interviews on 04/07/26 at 9:01 A.M. and 04/09/26 at 8:42 A.M., the resident said the following:-He/She always used oxygen at night and as needed during the day;-He/She did not usually have a bag to store the oxygen tubing. 5. Review of Resident #53's physician orders, dated 03/24/26, showed the following:-Diagnoses included right knee infected arthroplasty (joint replacement);-Wet to dry dressing (a traditional, mechanical debridement method used to remove dead tissue from open wounds by applying saline-moistened gauze, letting it dry, and removing it) with 2x2 gauze, cover with ABD dressing (a highly absorbent, sterile, and non-stick medical dressing designed for large, heavily draining wounds or surgical sites), and secure with ace wrap once a day. Review of the resident's care plan, last reviewed/revised on 03/26/26, showed the following:-He/She had impaired skin related to an open wound on his/her knee;-Dressing changes as directed by physician; wet to dry dressing daily using aseptic technique (a procedure that healthcare providers use to prevent the spread of infection). Review of the resident's wound documentation, dated 04/03/26, showed the following:-He/She had a 2.7 centimeter (cm) (length) by 3 cm (width) stable lesion that was present upon admission to the right knee. During an interview on 04/08/26 at 3:30 P.M., the resident said the wound on his/her right leg was caused by an infection after he/she had knee surgery. He/She acquired the infection prior to his/her admission to the facility, and he/she had been on intravenous (IV; medication administered through an access to the vein) antibiotics which had been discontinued. He/She continued to require daily dressing changes to the right knee. Observation on 04/08/26 at 3:35 P.M., showed the following:-LPN A removed the ace bandage and ABD pad from the resident's right knee/leg;-LPN A removed his/her gloves and without washing/sanitizing his/her hands, put on new gloves;-LPN A cleaned the wound with wound cleanser, did not remove his/her gloves, and moistened a clean 2x2 dressing with wound cleanser and placed the dressing on the right knee wound, covered the 2x2 with an ABD pad, secured with gauze cling, and wrapped the leg with ace bandage. (LPN A did not change his/her gloves after he/she removed the old dressing and cleaned the wound and before he/she applied the new dressing.) During an interview on 04/08/26 at 4:45 P.M., LPN A said he/she does not sanitize his/her hands when he/she removes his/her gloves. He/She washed his/her hands before and after the dressing change, and thought that was sufficient. During an interview on 04/09/2026 at 10:01 A.M., (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, observation, and record review, the facility failed to follow professional standards and the facility's policy/procedure for failing to complete a dressing change per proper technique for one resident (Resident #53) who had surgical wound and history of infection in the surgical wound which had recently been treated with antibiotics, in a review of 20 sampled residents. The facility census was 82. Review of the facility's undated clean dressing change checkoff showed the following:-Verify and review physician's orders;-Remove dirty dressing and place in trash can;-Clean wound with gauze and cleaning solution using a single outward strokes and separate gauze for each cleansing wipe;-Use dry gauze to pat the wound;-Apply clean dressing as ordered. Review of the National Library of Medicine, MedlinePlus.gov, last reviewed on 01/21/25, showed the following steps should be followed when changing a wet to dry dressing:-Pour saline into a clean bowl. Place gauze pads and any gauze packing tape you will use in the bowl;-Squeeze the saline from the gauze pads or packing tape until it is no longer dripping;-Place the gauze pads or packing tape in your wound. Carefully fill in the wound and any spaces under the skin;-Cover the moistened gauze or packing tape with a large dry dressing pad. Use tape or rolled gauze to hold this dressing in place. 1. Review of Resident #53's admission Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 01/26/26, showed the following:-His/Her cognition was intact;-He/She had a surgical wound. Review of the resident's physician's progress note, dated 03/12/26, showed the following:-The resident was status post right total knee arthroplasty (surgery to restore the function of a joint) that was complicated by a knee infection that required open debridement (the medical removal of dead, damaged, or infected tissue from a wound to promote healing and prevent infection) in September;-Cultures were positive for Staph epidermidis (common symbiont bacterium that can become infectious once inside the human host.);-He/She underwent surgery with replacement of the plastic in the joint on 12/02/25;-Examination showed an abscess of the right anterior aspect of his/her knee;-Diagnoses included an infection and inflammatory reaction due to an internal right knee prosthesis. Review of the resident's physician orders, dated 03/24/26, showed the following:-Right knee infected arthroplasty;-Wet to dry dressing (a dressing placed into a wound and allowed to dry before removing) with 2x2 gauze, cover with ABD dressing (a highly absorbent dressing designed for heavily draining wounds), and secure with ace wrap once a day. Review of the residents' care plan, last reviewed/revised on 03/26/26, showed the following:-He/She had impaired skin related to an open wound on his/her knee;-Dressing changes as directed by physician. Wet to dry dressing daily using aseptic technique (a procedure that healthcare providers use to prevent the spread of infection). Review of the resident's wound documentation, dated 04/03/26, showed he/she had a 2.7 cm (length) by 3 cm (width) stable lesion present upon admission to the right knee. During an interview on 04/08/26 at 3:30 P.M., the resident said the wound on his/her right leg was caused by an infection after he/she had knee surgery. He/She acquired the infection prior to his/her admission to the facility, and he/she had been on intravenous (IV; medication administered through an access to the vein) antibiotics which had been discontinued. He/She continued to require daily dressing changes to the right knee. Observation on 4/8/26 at 3:35 P.M. showed the following:-Licensed Practical Nurse (LPN) A removed the ace bandage and ABD pad from the resident's right knee/leg;-LPN A moistened a single 2x2 gauze with wound cleanser and cleaned the wound. LPN A wiped over the wound multiple times with the same 2x2 gauze;-LPN A moistened (not saturated) a clean 2x2 dressing with wound cleanser (not saline solution) and placed the dressing on the wound on the resident's right knee, covered the 2x2 with an ABD pad, secured with gauze cling, and wrapped the leg with ace bandage. During an interview on 04/08/26 at 4:45 P.M., LPN A said the dressing was supposed to be soaked in normal saline, but he/she did not have any normal saline. The order did not specify what to use, so he/she used the wound cleanser. He/She did not saturate the 2x2 gauze before he/she placed it on the wound. During an interview on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265590	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Manor	200 South St Paris, MO 65275

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/09/2026 at 10:01 A.M., the Director of Nursing said the following:-When completing a wet to dry dressing treatment, staff should place a 2x2 dressing in a cup of normal saline, wring out the 2x2 gauze but leave the dressing wet, and place the gauze over the wound. -LPN A should have used normal saline, not wound cleanser for the wet to dry dressing, per standard nursing protocol for wet to dry dressing changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide two residents (Resident #9 and #4), who relied on staff to assist with their activities of daily living (ADLs), in a review of 20 sampled residents, the necessary care to maintain good personal hygiene. The facility census was 82. Review of the facility policy, Perineal Care, dated March 2019, showed the following:-Purpose was to keep perineal clean and to prevent infection and odors in the perineal area;-Staff must clean all areas of the skin that are touched by soiled brief. Review of the facility policy, Indwelling Catheter Care, reviewed November 2025, showed when providing care to an uncircumcised male, retract the foreskin, cleanse the meatus as described, and return the foreskin to normal position. Review of Medline Plus Medical Encyclopedia, reviewed 07/01/25, showed the following:-Penis care (uncircumcised);-Gently retract the foreskin during bathing and clean the penis well. It is very important to reposition the foreskin back over the head of the penis after cleaning. Otherwise, the foreskin can slightly squeeze the head of the penis, causing swelling and pain. 1. Review of the Resident #9's quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by the facility, dated 03/06/26, showed the following:-He/She was occasionally incontinent of urine;-He/She was frequently incontinent of bowel;-He/She was dependent on staff for toileting and personal hygiene. Review of the resident's care plan, last reviewed/revised on 03/23/26, showed the following:-He/She had urinary and fecal incontinence related to decreased bladder/bowel control and cognitive/functional limitation as evidenced by episodes of wet/soiled briefs and need for assistance with toileting and hygiene;-Staff was to perform perineal care after each incontinence episode. Observation on 04/08/26 at 9:49 A.M. showed the following:-Certified Medication Technician (CMT) B and Licensed Practical Nurse (LPN) A assisted the resident to the toilet. The resident was incontinent of bladder and his/her incontinence brief and pants were soiled with urine. The resident had a bowel movement while on the toilet; -LPN A cleaned feces from the resident's rectal area; -Without cleaning the resident's front perineal area, LPN A and CMT B put a new incontinence brief on the resident, pulled up the resident's pants, and assisted the resident to the wheelchair. During an interview on 04/08/26 at 4:45 P.M., LPN A said he/she was not aware CMT B did not clean the resident's front perineal area. CMT B should have been cleaned the resident's frontal perineal area because the resident was incontinent of urine. During an interview 04/08/26 at 1:00 P.M., CMT B said LPN A was responsible to provide peri-care to the resident after the resident was incontinent of urine. He/She did not realize LPN A did not clean the resident's front perineal area. 2. Review of Resident #4's care plan, last reviewed/revised 02/17/26, showed the following:-The resident required a supra pubic catheter (a sterile tube inserted into the bladder through the abdominal wall to drain urine) related to stroke;-The resident was limited in ability to maintain his/her grooming/personal hygiene related to decreased mobility/stroke;-Provide assistance for washing/drying perineum as needed. Review of the resident's comprehensive MDS, dated [DATE], showed the following:-He/She had an indwelling urinary catheter;-He/She was dependent on staff for toileting hygiene. Observation on 04/08/26 at 7:09 A.M. showed the following:-CNA D and CNA C were in the resident's room to provide care for the resident;-CNA D pulled back the foreskin on the resident's genitalia to clean the area; -CNA D did not reposition the resident's foreskin back over the resident's genitalia once he/she provided perineal care. During an interview on 04/08/26 at 7:19 A.M., CNA D said he/she did not know he/she was supposed to reposition the foreskin to the normal position after providing care. During an interview on 04/08/26 at 7:26 A.M., CNA C said he/she was aware the resident's foreskin needed to be put back in place. He/She did not notice this when providing care. 3. During an interview on 04/09/26 at 1:16 P.M., the Director of Nursing (DON) said the following:-Staff should clean the front and back perineal areas when a resident was incontinent of urine; -After performing peri care for a male resident, staff should reposition the foreskin over the genitalia. If not, it could cut off circulation, cause a wound or cause an infection.