STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265621	A. Building B. Wing	04/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Livingston Manor Care Center	939 East Birch Chillicothe, MO 64601

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** 44993 Based on observation, interview and record review, the facilty staff failed to maintain standard infection control precautions when staff did not perform hand hygiene with glove changes during wound care for two residents (Resident #1 and #2). Additionally, staff did not wear a personal protective gown when assisting with wound care for Resident #2 when the resident was on Enhanced Barrier Precautions (EBP). The facility did not have gowns near or outside of the resident rooms. The facility did not obtain a physicians order to implement EBP when Resident #1 and #2 had wounds. This deficient practice affected two of two sampled residents. The facility census was 33. Review of the facility policy titled, Hand Hygiene, dated 1/1/24 showed: - Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of Practice; - The use of gloves does not replace hand hygiene; - Perform hand hygiene prior to putting on gloves, and immediately after removing gloves. Review of the facility policy titled, Infection Prevention and Control Program, dated 1/124 showed: - Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures; - All staff shall use personal protective equipment (PPE) according to established facility policy. Review of the facility policy titled, Enhanced Barrier Precautions, dated 3/23/24 showed: - EBP refers to an infection control intervention designed to reduce the transmission of multi-drug-resistant organisms that employs targeted gown and glove use during high contact resident care activities; - Make gowns and gloves available immediately near or outside of the resident's room; - High contact resident care activities include wound care; - The facility staff with obtain a physician's order when a resident is placed on EBP precautions. (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	1. Review of Resident #1's admission Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 3/12/25 showed: - He/She had a Brief Interview for Mental status score of 10, indicating moderate cognitive impairment; - Diagnoses included: Heart Failure (HF), urinary tract infection (UTI), stroke, and anxiety; - He/She was dependent on the staff to toilet, get dressed and shower; - He/She was at risk for the development of pressure ulcers; - He/She did not have any pressure ulcers. Review of the resident's comprehensive care plan dated 3/8/25 showed the resident's wounds were not addressed. Review of the Physicians Order Sheet (POS) dated 4/2025 showed: - 3/24/25 Left 1st toe, cleanse the area with wound cleanser (WC), apply silver sulfadiazine (a wound treatment to promote healing) and calcium alginate, cover with a non stick pad, wrap in kerlix (a gauze that is wrapped around the area) and an elastic bandage. Change every Monday, Wednesday and Friday; - 3/24/25 Left toes, apply anti-fungal powder in between each toe before wrapping in kerlix and elastic bandage; - 3/24/25 Left and right heels, apply betadine (a liquid that cleans) and foam to both heals, cover with a border gauze dressing one time daily; - The orders did not include an order for EBP. Observation on 4/5/25 at 11:0 A.M. showed: - There was no PPE cart in or near the resident's room; - There was no signage in or near the resident's room indicating staff were to adhere to EBP precautions; - Licensed Practical Nurse (LPN) A and Certified Nurse Aide (CNA) A entered the resident's room; - LPN A pushed the treatment cart into the room; - CNA A did not wash his/her hands prior to putting on gloves; - LPN A washed his/her hands and put on gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- LPN A pushed his/her glasses up on his/her face with his/her gloved fingers and the finger of the gloves touched his/her side of nose; - CNA A lifted the resident's leg up and LPN A began cutting the dressing from the resident's right foot; - LPN A removed the dressing and grabbed cleaning gauze pads from the top of the cart with the same gloves on; - LPN A opened the cart and dug through it to get the wound cleanser with the same gloves on; - LPN A cleaned the resident's open wound with the same gloves on; - LPN A removed the used gloved and put on clean ones, he/she did not perform hand hygiene before putting on clean gloves; - LPN A applied the ordered treatment and replaced the dressing to the resident's right foot; - CNA A set the resident's right foot down and lifted the resident's left foot; - LPN A removed the dressing from the resident's left foot, cleaned the wounds with wound cleanser and did not put on clean gloves; - LPN A touched his/her nostril area of his/her nose with his/her gloved right hand; - LPN A placed a clean dressing to the reisdent's wounds and did not change his/her gloves; - LPN A pushed his/her glasses up onto his/her face wearing the same gloves; - LPN A then took off the used gloves and washed his/her hands before exiting the room; - CNA A removed his/her PPE and did not was his/her hands before leaving the resident's room. During an interview on 4/5/25 at 11:17 A.M. CNA A said: - He/She did not know the staff were supposed to adhere to EBP precautions; - He/She had not received educations regarding EBP; - He/She put a protective gown on because LPN A told him/her to; - He/She knew he/she was supposed to wash his/her hands when entering and exiting the resident's room. During an interview on 4/5/25 at 11:27 A.M. LPN A said: - The staff were supposed to adhere to EBP precautions because the resident had a wound; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- He/She should have washed his/her hands upon entering and exiting the reisdent's room; - HE/She should have changed his/her gloves and performed hand hygiene before putting on clean gloves prior to cleaning the reisdent's wounds, and prior to completing the wound treatment; - He/She should have changed his/her gloves and performed hand hygiene when he/she touched his/her face and nostrils; - He/She should not have dug in the treatment cart with contaminated gloves on. 2. Review of Resident #2's quarterly MDS dated [DATE] showed: - He/She had a BIMS score of 15, indicating no cognitive impairment; - Diagnoses included: multi-drug resistant organism and anxiety; - The resident was dependent on staff assistance to toilet, get dressed and bathe; - The resident was at risk for the development of pressure ulcers; - The resident had one stage 4 (a pressure ulcer with exposed tendons and bone), and six stage 2 (pressure ulcer characterized by the top layer of skin opened). The reisdent's wound care plan dated 1/30/25 showed: - The staff were supposed to complete wound treatments as ordered by the physician; - Resident was to be monitored for signs and symptoms of infection; - The resident's care plan did not address EBP. Review of the resident's POS dated 4/2025 showed: - 4/4/25 Cleanse the area with Vashe cleanser (wound cleanser), apply betadine to the edges of the wound, calcium alginate with silver to the wound bed, cover with a foam border dressing. Change three times per week on Monday, Wednesday and Friday; - There was no order for EBP. Observation on 4/5/25 at 9:54 A.M. showed: - There was no PPE cart in or near the resident's room; - There was no signage in or near the resident's room indicating EBP precautions; - LPN A placed the resident's treatment items on top of the treatment cart; - LPN A put on a protective gown and entered the resident's room with the treatment cart; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- CNA A entered the resident's room and did not put on a protective gown; - LPN A and CNA A did not wash their hands upon entering the residents room; - Both staff put on gloves; - CNA A rolled the resident's to his/her side; - LPN A removed the old dressing from the resident's wound; - LPN A pushed his/her glasses up onto his/her nose with the back of his/her gloved hand; - LPN A did not change his/her gloves after touching his/her glasses; - LPN A cleaned the resident's wound and did not change his/her gloves; - LPN A applied a new wound dressing with his/her contaminated gloves; - LPN A took his/her dirty gloves off and put on clean gloves, LPN A did not perform hand hygiene with the glove change; - LPN A touched his/her face and nostril with his/her gloved fingers; - LPN A dug through his/her pocket and pulled out a pen; - LPN A wrote the date on the resident's wound dressing; - LPN A and CNA A removed his/her gloves and left the residents room with out performing hand hygiene. 3. During an interview on 4/5/25 at 11:52 A.M. the Director of Nursing (DON) said: - She expected all staff to wear protective gowns when they are assisting with wound care; - She expected hand hygiene to be completed between glove changes; - She expected staff to wash their hands when entering a resident's room and exiting; - She expected staff to change their gloves and perform hand hygiene when they have touched their face, nostril, and glasses; - She expected staff to change their gloves and perform hand hygiene when they remove an old wound dressing, again when cleaning the wound, again when applying a new treatment and dressing, and if visibly soiled; - Staff should not dig in their pockets or the treatment cart with gloved hands; she expects staff to have all of the materials needed for the treatment prepared and easily accessible; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There should be a PPE cart in or near the resident's room, so that staff have easy access to PPE; - There should by signage in or near the resident's room to alert staff the resident's was receiving EBP precautions; - She expected EBP to be care planned and a physician's order obtained. MO252238