STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265664	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation, interview, and record review, the facility failed to treat all residents with dignity and respect when staff used an inappropriate tone of voice and a public location to discuss concerns with one resident (Residents #22) and when one staff member (Certified Nurse Aide (CNA) A) cursed and used a disrespectful name in the presence of a resident, transferred a resident in a rough manner, and tossed a draw sheet while assisting a resident for one resident (Resident #19). The facility census was 101. A sample of 27 residents was reviewed; the facility census was 101. Review of a facility's policy titled Dignity, revised 02/2021, showed the following: -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem; -Residents are treated with dignity and respect at all times; -Honor resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay; -Individual needs and preferences of the resident are identified through the assessment process; -Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice. Review of the facility policy titled Resident Rights, dated December 2016, showed the following: -Federal and state laws guarantee certain basic right to all residents of this facility; -These rights include the resident's right to be treated with respect, kindness, and dignity. 1. Review of Resident #22's face sheet (gives basic profile information) showed the following: -admitted [DATE]; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included multiple sclerosis (MS - disease causing nerve damage which disrupts communication between the brain and the body; may result in impaired movement, vision loss, pain, and fatigue), muscle wasting and weakness, left femur (leg) fracture, diabetes, muscle spasm and pain of lower back, anemia (low red blood cell count), depressive disorder, urinary incontinence, high blood pressure, history of mini-stroke, and generalized anxiety disorder. Observation on 07/23/24, at 4:40 P.M., showed the resident sat in his/her power chair in the facility's library room. The library was approximately 10 feet by 8 feet in size with a large windows on adjacent sides that allowed visibility into the room. The room's door was closed. Certified Nursing Assistant (CNA) K, CNA N, and CNA O sat in chairs surrounding the resident. Licensed Practical Nurse (LPN) L stood approximately three feet in front of the resident, leaning into him/her. The LPN shook his/her splayed hands out to his/her front/sides and loudly demanded, What do you want us to do?! CNA K came out of the room and went to talk to Assistant Director of Nursing (ADON) R. The ADON entered the library at that time and began talking to the resident. During an interview on 07/23/24, at 4:55 P.M., the resident said during the event in the library, he/she was frustrated, saying We weren't getting anywhere! It was just a 'he said/she said' argument. The staff wasn't listening to me, and they said I wasn't hearing them! The resident said following a disagreement with the CNAs in his/her room, the nurse said they would go to the library to discuss the situation. The resident said he/she was upset, so he/she went into the room of another resident to briefly talk to them. While in that room, the door accidentally closed, and the resident was unable to re-open it due to his/her power chair. LPN P knocked on the door and loudly called out, Come on, we're waiting on you! During an interview on 07/25/24, at 9:37 A.M., the resident said he/she felt like the four staff were ganging up on me during the discussion in the library on 07/23/24. The resident said he/she felt intimated. During an interview on 07/24/24, at 3:50 P.M., CNA N said the group discussion in the library was due to a disagreement between the resident and aides regarding the prioritizing/timing of residents' cares, resulting in the resident telling all of the aides to just leave the room. LPN L came and took the CNAs and resident into the library. During the conversation, CNA K told CNA N the discussion wasn't productive and left the room to get ADON R. CNA N said LPN L and the resident was trying to work it out, but it was just a 'he said/she said' argument. CNA N said he/she wasn't comfortable with the situation and thought management should have been involved. During an interview on 07/24/24, at 4:05 P.M., CNA O said he/she, CNA K, and CNA N had a disagreement with the resident regarding the prioritizing of residents' cares. When the aides said they didn't want to argue about it, the resident told them all to leave his/her room. LPN L suggested they all go to the library to avoid talking in front of the resident's roommate. CNA O said the aides didn't really talk much, LPN L and then later ADON R, did the talking. The resident was a bit upset, insisting I needed to lay down, but you kept taking care of everyone else! The staff was explaining the need to prioritize care. CNA K went to get ADON R, who sat down across from the resident to explain the aides' actions. CNA K and CNA N apologized to the resident, who then allowed them to assist him/her to bed without telling them to leave. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/25/24, at 4:05 P.M., LPN L said staff should help residents maintain their dignity and a dignified appearance. The LPN said on 07/24/24, at around 4:00 P.M., he/she sent staff to put the resident in bed. When the aides reported to LPN L that the resident had sent them all out of the room, LPN L went to the resident, who was then out in the hall, and asked him/her the reason. The resident said it was because they told her they weren't going to put up with my talking about another resident's care. LPN L said he/she wanted to talk about what was said and how the resident interpreted it. LPN L started to take the three staff into the resident's room to discuss the situation, but the resident didn't want to talk in front of the roommate. LPN L suggested they go to the library. The LPN said nobody raised their voices, and the staff wasn't trying to intimidate the resident by all of them being present. LPN L said he/she suggested the library because the resident likes it in there. The LPN said he/she had not noticed that the discussion was audible and visible to anyone who was in the front lobby area and maybe he/she should have better managed the issue by talking to the resident one-to-one instead of with all of the aides there. During an interview on 07/26/24, at 2:22 P.M., the Director of Nursing (DON) said staff should treat residents in a dignified manner. If there is a need to discuss a resident's concerns, needs, or a situation regarding the aides, the charge nurse, not a group of staff, should remove the aides from the situation and speak calmly with the resident one-to-one. During an interview on 07/26, 24, at 3:00 P.M., the Administrator said staff should not stand over a resident or have a group of staff confronting the resident to discuss a disagreement; that might be appear to be undignified and possibly intimidating to the resident. Appropriate staff (the charge nurse, DON or Administrator) should meet with the resident one-to-one to de-escalate the situation. 2. Review of Resident #19's face sheet showed the following: -admitted [DATE]; -Diagnoses included multiple sclerosis (chronic, typically progressive disease involving damage to the sheaths of nerve cells in the brain and spinal cord, whose symptoms may include numbness, impairment of speech and of muscular coordination, blurred vision, and severe fatigue), dementia (chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) without behavioral disturbance, Alzheimer's disease with late onset (progressive disease that destroys memory and other important mental functions) , generalized anxiety disorder, and age-related physical debility (the state of being weak in health or body). Review of the resident's care plan, last updated 02/05/24, showed the following: -The resident lacked the capacity to understand and make decision regarding healthcare; -The resident has an ADL self-care performance deficit; -The resident required extensive assistance of one staff for toilet use; -The resident required substantial/maximum assistance by two staff for all transfers; -The resident had limited physical mobility; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident was totally dependent on one staff for locomotion using wheelchair; -Staff should provide supportive care and assistance with mobility as needed; -When resident became agitated staff to interview before agitation escalated; guide away from source of distress; and engage calmly in conversation. If response was aggressive, staff should walk calmly away and approach later; -The resident had impaired cognitive function/dementia or impaired thought process, -Staff should engage in conversation about a pleasant topic before initiating care; -Staff should use positive approach techniques including approach resident from the front and use a wave and extend your hand for a handshake. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 07/04/24, showed the following: -Severe cognitive impairment; -Resident required substantial/maximal assistance for toileting hygiene; -Resident required partial/moderate assistance for dressing; -Resident required use of a wheelchair for mobility. Review of the resident's nursing progress note dated 07/21/24, at 3:19 P.M., showed during the course of the day, there was an alleged incident of verbal abuse from a staff member. Statements were gathered and the event was reported to the Director of Nursing (DON) and Administrator. Staff informed physician, family member, and on-call nurse for hospice. The staff member was released from duty pending the investigation. Nurse completed head to toe assessment with no finding. The resident was alert to self only and could not make any statement about the incident. Review of the interview statement, dated 07/22/24, completed by the Administrator and an Assistant Director of Nursing (ADON) with CNA B, showed the following: -CNA B went to the shower room. CNA A and the resident were already present. The resident was screaming help. CNA A stood the resident up and CNA B pulled down the resident's pants. CNA A pivot transferred the resident to the toilet by throwing him/her. The Administrator and ADON asked CNA B to demonstrate the transfer. From CNA B's description, the resident was not thrown, but transferred in a rough manner. -CNA A then left to collect a fresh brief and pants. While CNA A was gone the resident stated, I'm not getting a shower. CNA B reassured the resident that he/she was only getting cleaned up. -CNA B put the brief and pants around the resident's leg. CNA A stood the resident up. The resident had another bowel movement. CNA B cleaned the resident up again. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA C entered the room. CNA A pivot transferred the resident back to the chair. During the transfer CNA A said to the resident, you sound like a fucking [NAME] goat. After the transfer, CNA B took the foot pedals back to the room. CNA B went to the charge nurse and reported the incident. Review of the written statement, dated 7/21/24, completed by CNA A showed the following: -While working with CNA B, they took the resident to the shower room to change his/her brief. CNA C came in to talk with CNA B. The resident was yelling, and CNA A said to both co-workers that the resident sounded like a [NAME] goat. CNA B and CNA A then stood the resident and pulled up his/her pants. CNA A took the resident to his/her room. -CNA C and CNA A both were in the resident room when CNA A transferred the resident. When CNA A pulled the blankets down, he/she tossed the stained pull sheet out in the hallway, covered the resident up, and pushed the wheelchair to the hallway. During an interview on 07/25/24, at 1:23 P.M., CNA A said the following: -The resident was upset in the hallway and was trying to climb out of his/her chair. The resident was crying loud pitch noises which was not his/her normal. The resident said he/she wanted to go to bed. He/she took the resident to the big bathroom in the hallway, toileted the resident, and then took the resident back to his/her room and transferred to him/hr to bed. CNA A said that he/she tossed the dirty pull sheet to the hallway. He/she did not put another draw sheet because the resident was anxious; -In the shower room, he/she said to another co-worker that when the resident was crying he/she sounded like a baby [NAME] goat. The aide said this to the coworker in a low voice. The resident was in the room, but was hard of hearing. CNA A said that he/she should not have done that. The aide said he/she was not rough with transfer; -CNA A said that he/she was going to lay down the resident, but knew he/she needed changed first. The resident was a two-person transfer to the toilet, the aide said that he/she assisted the resident to stand up and CNA B pulled up the resident's pants. CNA A pivoted the resident and sat him/her back down, this was not rough or hard. Review of the written statement, dated 07/21/24, completed by CNA B showed the following: -CNA A took the resident in the main shower room on 300 hall. CNA A picked the resident up and threw him/her on the stool. CNA A said I am mad. CNA B said okay, I'm sorry. CNA A went and got the resident's pants. CNA A stood the resident up and CNA B wiped the resident. CNA C was in the room now. As they were cleaning the resident CNA A said I'm going to start calling you a fucking goat. Then he/she threw the resident in his/her chair. CNA A was cussing about Registered Nurse (RN) D and saying this is not how you treat your aides; -CNA A is frequently rude to residents and always cussing. During an interview on 07/26/24, at 9:05 A.M., CNA B said he/she did not feel CNA A mean to intentionally do anything to the resident, he/she was having a bad day. (continued on next page)

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F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of the written statement, dated 07/21/24, completed by CNA C showed the following:

-When CNA C walked into the shower room, CNA C was looking for CNA B and was told that was where he/she was.

-When CNA C walked in CNA B was cleaning up the resident and CNA A said the resident sounded like a fucking goat.

-CNA C grabbed the chair and CNA A put the resident in the chair roughly. CNA C then followed CNA A and CNA B to the resident's room. CNA B left and CNA A started to put the resident into bed and he/she proceeded to throw the dirty pull sheet out into the hallway.

During an interview on 07/26/24, at 8:50 A.M., CNA C said the following:

-On Sunday, 07/21/24, he/she walked into the shower room and two aides were giving care to the resident. CNA A was holding up the resident and CNA B was cleaning the resident. He/she moved the wheelchair closer and asked what the resident was yelling about. CNA A looked at the resident and said you shit yourself. CNA A then pivoted the resident to the wheelchair, but instead of sitting the resident into the wheelchair, he/she just dropped the resident into the wheelchair and the resident had a rough landing. CNA A grabbed the wheelchair to take back to his/her room.

-The resident said something about not being clean or not being done. CNA A was argumentative, so CNA C said let's just get the resident back to his/her room for now. CNA B left the room. CNA C and CNA A went into the resident room.

-As the staff got the resident into his/her bed there was a stain or dirty mark on the draw sheet, CNA A threw the sheet out into the hallway. CNA A said the resident sounded like a fucking [NAME] goat. He/she was looking at the resident when he/she said this.

During an interview on 07/23/24, at 3:50 P.M., the resident's roommate, Resident #67, said CNA A was rude and hateful. Resident #67 said he/she asked CNA A for wash rags and towels and the aide told the resident that he/she did not have time for that.

During an interview on 07/24/24, at 3:15 P.M., Resident #17 said that he/she had seen CNA A be rude and rough with the resident.

During an interview on 07/24/24, at 12:10 P.M., CNA K said he/she had worked with CNA A and had seen CNA A have a rude tone and attitude to staff and residents.

During an interview on 07/25/24, at 1:43 P.M., RN D said the following:

-CNA B and CNA C reported to him/her that the resident was transferred roughly and verbal abuse occurred, including general cursing. He/she then contacted the DON and was told to escort CNA A out of the building. He/she completed a full assessment on the resident. He/she asked questions of the resident with no response. The resident was at his/her baseline and was not fearful. The RN contacted the family and the physician and hospice and no new orders were received. The RN had witnessed CNA A's attitude but not to any one person;

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-he RN said that Resident #17 mentioned that he/she had witnessed CNA A move the resident roughly before; -The RN said he/she would tell the DON if any resident stated that staff were rude. During an interview on 07/25/24, at 3:45 P.M., LPN L said that it was not appropriate for staff to call resident names even to each other. During an interview on 07/26/24, at 9:15 A.M., CMT M said it was not appropriate for staff to call any resident disrespectful names while standing over the resident or with the resident in the room. If needed, staff should talk to co-worker in a private area. During an interview on 07/25/24, at 2:03 P.M., the DON said the following: -Was made aware of allegation of abuse when CNA B sent a text; -The DON called RN D and he/she said the aides just came to him/her and he/she went to make sure the resident was safe; -It was not appropriate to call a resident a [NAME] goat, even if not talking to the resident; -Staff should not talk over residents to talk each other and should not call residents derogatory names. This was not dignified behavior. During an interview on 07/26/24, at 3:00 P.M., the Administrator said the following: -Was notified on Sunday, 07/21/24, of an incident and then came into the building and took some staff interviews; -It is not appropriate for staff to call residents disrespectful names. The residents have rights and they have names. MO00239286 41787

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on interview, observation, and record review, the facility failed to facilitate and support each resident's right to self-determination when staff failed to provide baths/showers to two residents (Resident #46 and #49) as requested and care planned. A sample of 27 residents was reviewed in a facility census with a census of 101. Review showed the facility did not provide a policy related to showers/bathing of residents. 1. Review of Resident #46's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses include: cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), systemic lupus erythematosus (SLE - an autoimmune disease, the immune system of the body mistakenly attacks healthy tissue), cognitive communication deficit, and congestive heart failure (CHF - condition in which the heart cannot pump enough blood to the body's other organs). Review of the resident's care plan, last reviewed on 03/08/24, showed the following: -The resident had an activities of daily living (ADL) self-care performance related to weakness and non-ambulatory status; -Staff should offer two baths/showers per week and as needed; -Resident required extensive assistance of one staff for bathing/showering. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 06/04/24, showed the following: -Moderate cognitive impairment; -Required partial to moderate assistance with showering/bathing; -Independent with transfers. Review of the resident's ADL sheet titled Bathing Monday & Thursday & PRN (as needed), dated 06/01/24 to 07/29/24, showed staff documented the following: -On 06/05/24, the resident received a shower; -On 06/12/24, the resident received a shower (seven days after the previous shower); (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 06/19/24, the resident received a shower (seven days after the previous shower); -On 06/24/24, the resident received a shower; -On 07/08/24, the resident received a shower (14 days after the previous shower); -On 07/18/24, the resident received a shower (10 days after the previous shower); -On 07/29/24, the resident received a shower (11 days after the previous shower). Observation and interview on 07/23/24, at 1:15 P.M., showed the resident said he/she would like showers more often. He/she only get a shower once per week. He/she felt dirty and tired when not clean. He/she was scheduled for showers on Monday and Thursdays. He/she said when received, showers twice week was good enough, but that once per week was not enough. The resident's hair was uncombed and dull. 2. Review of Resident #49's face sheet showed the following: -admitted [DATE]; -Diagnoses included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), dependence on wheelchair, acquired absence of right leg and left leg above the knee (limb was amputated), chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic respiratory failure a with hypoxia (condition not have enough oxygen in the tissues in the body), and obstructive and reflux uropathy (urine cannot drain through the urinary tract, and may back up into the kidneys). Review of the resident's significant change MDS, dated [DATE], showed the following: -Cognitively intact; -Required substantial to maximal assistance with showering/bathing; -Dependent on staff for transfers. Review of the resident's care plan, last reviewed 07/18/24, showed the following: -The resident had an ADL self-care performance deficit related to bilateral above the knee amputation; -The resident preferred bathing/showering on Monday, Thursday, and as needed; -The resident required extensive assistance of one staff for bathing/showering; -The resident required extensive assistance of two staff for bed mobility; (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident required mechanical lift, Hoyer, with two staff assistance for transfers. Review of the resident's ADL sheet, titled Bathing Monday & Thursday & PRN, dated 06/01/24 to 07/29/24, showed staff documented the following: -On 06/11/24, the resident received a bed bath (at least 11 days after the previous bath/shower); -On 06/13/24, the resident received a shower; -On 06/25/24, the resident received a shower (12 days after the previous shower); -On 07/24/24, the resident received a shower (one month after the previous shower); -On 07/28/24, the resident received a bed bath. Observations and interview on 07/23/24, at 11:16 A.M., showed the resident said he/she had not had any shower or bed bath since 07/03/24, when came off hospice. The resident's hair had a greasy, oily, and dull appearance. The resident said he/she needed a shower. He/she felt crusty, dirty, nasty, and smelled without a shower. The resident said he/she had agreed to a full shower one to two times per month because he/she did not tolerate the Hoyer lift (mechanical device with a sling attached to lift and transfer a non-ambulatory resident) well with skin issues on the back side. He/she thought at one time the physician ordered for him/her to receive bathing/shower five times per week, but he/she would settle for twice per week. During an interview on 07/26/24, at 12:30 P.M., Certified Nurse Aide (CNA) S said residents on hospice services should be offered showers from the facility staff as well. The resident just came off hospice and the resident's hospice staff was great about getting him/her cleaned. The resident took two showers per month and the rest of the time had bed baths. He/she did not provide showers last week as the resident was still on hospice. 3. During an interview on 07/26/24, at 10:25 A.M., Licensed Practical Nurse (LPN) G said that showers are done by shower aides with the schedule they had. He/she had not seen any residents not appear clean or heard of no shower for weeks. 4. During an interview on 07/26/24, at 12:30 P.M., CNA S said that he/she had a shower list and that residents should be offered two showers per week. Some residents only take one per week. 5. During an interview on 07/26/24, at 2:20 P.M., the Director of Nursing (DON) said staff should offer two showers/baths per week, even if on hospice service. Staff should communicate in report if a resident was no longer on hospice although nothing should change because staff should already be offering two shower/baths per week. Residents should not have to wait 20 days to have a shower/bath. 6. During an interview on 07/26/24, at 3:00 P.M., the Administrator said staff should offer residents showers/baths two times per week even if on hospice. Residents should not have to wait three weeks for shower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265664	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to ensure each resident's personal privacy was protected when staff failed to shut the door for one resident (Resident #6) while providing personal care exposing him/her to anyone passing the room. The facility census was 101. Review of the facility's policy titled Dignity, last revised in February 2021, showed the following information: -Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem; -Residents' private space and property are respected at all times; -Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 1. Review of the Resident #6's face sheet showed the following information: -admitted [DATE]; -Diagnoses include diabetes, obesity, Alzheimer's disease, chronic kidney disease, and major depressive disorder. Review of the resident's quarterly Minimum Data Sheet (MDS - a federally mandated assessment tool filled out by facility staff), dated 05/01/24, showed the following information: -Moderate cognitive impairment; -Dependent on staff for all personal cares and mobility; -Incontinent of bowel and bladder. Review of the resident's care plan, last revised on 10/17/22, showed extensive assist of two staff required for personal care. Observation on 07/25/24, at 10:37 A.M., showed the resident's room door open with the the resident's unclothed back of his/her body visible from the hall. The resident was laying on his/her left side facing toward Certified Nursing Assistant (CNA) E. The resident was undressed from the waist down. CNA said oh, sorry, I should have pulled this. CNA E left the side of the resident and pulled the curtain to provide privacy. CNA E said he/she was performing incontinence care and had just finishing up. During an interview on 07/26/24, at 9:15 A.M., the resident said he/she did not particularly like his/her whole body shown to the hall, but his/her roommate likes the door open, so it is often left open during care. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/26/24, at 9:39 A.M., Certified Nursing Assistant/Certified Medication Technician (CNA/CMT) F said a resident's bare body should never be seen from the hallway. Staff should provide privacy for the resident prior to providing care. The resident's roommate has claustrophobia (a fear of confined spaces), so he/she does not like the door to be closed often. But, in that case, staff should still pull the privacy curtain. During an interview on 07/26/24, at 9:50 A. M., Licensed Practical Nurse (LPN) G said he/she expected staff to provide privacy during care by closing the curtain around them. There should never be any instance when walking down the hall should you see an unclothed resident. During an interview on 07/30/24, at 12:08 P.M., the Admissions Coordinator said it is never acceptable to be able to see an exposed resident from the hallway. During an interview on 07/30/24, at 1:33 P.M., the Director of Nursing (DON) and Administrator agreed and said that residents' doors and curtains should not be open while incontinent care is being performed.

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F 0584

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41787

Based on observation, interview, and record review, the facility failed to provide a clean, safe, and comfortable homelike environment for all residents when when staff failed to repair a stained ceiling, and failed to keep the floor free from debris for one resident (Resident #70); when staff failed to repair wall damage for one resident (Resident #30); and when staff failed to maintain wall outlets for one resident (Resident #49). The facility census was 101.

Review of the facility policy titled Homelike Environment, dated February 2021, showed the following:

-Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible;

-The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting including a clean, sanitary and orderly environment.

1. Review of Resident #70's face sheet (brief information sheet about the resident) showed the following:

-admitted [DATE];

-Diagnoses included hemiplegia and hemiparesis (paralysis) following cerebral infarction (stroke) affecting left non-dominant side, spondylosis of thoracolumbar region (natural wearing down in the mid-back), repeated falls, and generalized anxiety disorder.

Review of the resident's care plan, last updated 04/02/24, showed the resident had an activities of daily living (ADL) self-care performance deficit related to weakness.

Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 05/27/24, showed the resident cognitively intact and use of manual wheelchair.

Observation and interview on 07/25/24, at 11:03 A.M., showed the following:

-The resident said there was trash under the bed and under the recliner that the housekeeping staff would not clean up. There were also several stains on the ceiling;

-Observation showed multiple pieces of trash and debris, including food crumbs, medication cups, paper, tissue, under the resident's bed and behind the bedside recliner;

-Observation showed stained area on the ceiling directly above the resident's bed approximate 6-inch diameter stain with a black ring, pink ring, and brown discoloration in the stain;

(continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Observation showed two stained appearance spots around smoke detector above the resident's dresser area that were brown discoloration in appearance and extended around the smoke detector about two inches round; -The resident said that the stains and trash were bothersome and made him/her feel that the room was dirty. Review of the Maintenance Request Log at the 300 hall nurses' station showed the following: -On 05/26/24, leak by the smoke detector. The entry was initialed by someone other than the current Maintenance Director; -No entry documented regarding ceiling damage above the bed. 31464 2. Review of Resident #30's face sheet showed the following information: -admitted [DATE]; -Diagnoses included anemia (low red blood cell count), paraplegia (loss of muscle function in the lower half of the body), left above-knee amputation (AKA) with phantom limb pain, high blood pressure, obstructive uropathy (causes impaired urinary elimination), chronic obstructive pulmonary disease (COPD - breathing disorder), and respiratory failure. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Utilized a motorized wheelchair; -Dependent on staff for transfers between chair/bed. Review of the resident's care plan, last updated 05/23/24, showed the resident had capacity to understand and make decisions and resident has limited physical mobility related to left above the knee amputation and right leg brace for foot drop; Observation and interview on 07/24/24, at 12:50 P.M., showed the following: -The resident pointed out wall damage to the corner of the wall next to the closet. He/she said staff had driven his/her power chair into it on occasion, knocking off the clear plastic protective covering and leaving the metal drywall corner bracket revealed. Observation at the time of the interview confirmed the damage. -The resident said the peeled portion of the wall/wallpaper above his/her bed looked like (the shape of) a pregnant woman. I needed to move my plant over there to cover it up! Observations at the time of the interview confirmed the peeling wall paper. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident said the new maintenance staff was working hard to make repairs that had been needed for quite a while. Review of the Maintenance Request Log at the 300 hall nurses' station showed the no entries documented regarding wall damage. 3. During an interview on 07/26/24, at 9:05 A.M., Certified Nursing Assistant (CNA) B said that if he/she had any environment concerns, he/she would notify the maintenance staff, and there was a maintenance log at the nursing station that information could be added to. He/she had not been told by any residents of environment concerns. He/she had seen holes and tears in the walls of various resident rooms. 4. During an interview on 07/26/24, at 9:15 A.M., Certified Medication Technician (CMT) M said that any environment concerns should be written on the maintenance log that was located on the 100/200 hall nurse desk. He/she was not aware of any residents with complaints of room repairs needed. 5. During an interview on 07/26/24, at 10:25 A.M., Licensed Practical Nurse (LPN) G said that staff should notify the maintenance staff any time concerns in any resident rooms or common areas. He/she was not aware of any resident room concerns. 6. During an interview on 07/26/24, at 10:35 A.M., Registered Nurse (RN) D said that staff should notify the maintenance staff of damage in resident rooms. He/she was not aware of stained ceiling or resident rooms not cleaned. 7. During an interview on 07/26/24, at 11:10 A.M., the Maintenance Director said staff should write any maintenance concerns on the log at the nurses' stations, or they could verbally notify him. He was currently trying to fix holes in walls, closets, and doors, and would assist with the current process involving new floors in the 400 hall. He was aware of some large holes in various rooms, but not aware of any damage on the 300 hall at that time. 8. During an interview on 07/26/24, at 3:00 P.M., the Administrator said that resident rooms should not have large holes in walls, doors, or closets. The rooms should not have stained ceilings. The maintenance staff was trying to catch up on facility repairs. Staff should notify the Maintenance Director for repairs or damage to resident rooms. 9. Review showed the facility did not provide a policy regarding electrical outlet monitoring. Review of Resident #49's face sheet showed the following: -admitted [DATE]; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), dependence on wheelchair, acquired absence of right leg and left leg above the knee (limb was amputated), chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic respiratory failure a with hypoxia (condition not have enough oxygen in the tissues in the body), and obstructive and reflux uropathy (urine cannot drain through the urinary tract, and may back up into the kidneys). Review of the resident's significant change in status Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/07/24, showed the following: -Cognitively intact; -Required substantial to maximal assistance with showering/bathing; -Dependent on staff for transfers. Review of the resident's care plan, last reviewed 07/18/24, showed the following: -The resident had an activities of daily living (ADL) self-care performance deficit related to bilateral above the knee amputation. Observation and interview on 07/25/24, at 10:53 A.M., showed the following: -The resident said the electrical outlet behind the small bedside table in his/her room was significantly loose. He/she said that no plug would remain plugged in without being propped up by the bedside table. The resident said he/she cannot plug his/her cell phone into the outlet because it will not stay plugged in. He/she said that he/she had notified staff several times; -Observation of the outlet showed the resident's CPAP machine (continuous positive airway pressure - machine that uses mild air pressure to keep breathing airways open while sleeping) plugged into the outlet with most of the silver prongs visible and loosely hanging into the outlet. The back of the bedside table was touching the electrical cord. During interview on 07/26/24, at 11:10 A.M., Maintenance Director said the following: -He checked electrical outlets for receptacle retention tests and was not aware of any outlets that are loose at this time; -Staff should notify maintenance of items in need of repair or write on the maintenance log at the nursing station; -Plugs should not be hanging out of the wall or propped up by furniture. During an interview on 07/26/24, at 2:20 P.M., the DON said outlets should not have furniture propping up plugs and staff should notify maintenance for repair. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/26/24, at 11:46 A.M., the Administrator said plugs should not be supported by furniture to stay in the outlet.

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on record review and interview, the facility failed to notify the resident and the resident's representative in writing, as soon as practicable, of a transfer or discharge to a hospital that included the reason for the transfer, date of transfer, and destination of transfer for three residents (Residents #30, #65, and #70) out of 10 sampled residents. The facility census was 101. Review showed the facility did not provide a policy regarding written transfer notices upon a resident's transfer to the hospital. 1. Review of Resident #30's face sheet (gives basic profile information) showed the following information: -admitted to the facility on [DATE] and readmitted on [DATE]; -Diagnoses included anemia (low red blood cell count), paraplegia (loss of muscle function in the lower half of the body), left above-knee amputation (AKA), high blood pressure, obstructive uropathy (causes impaired urinary elimination), chronic obstructive pulmonary disease (COPD - breathing disorder), and respiratory failure. Review of the resident's progress notes showed staff documented the following information: -On 02/01/24, at 12:26 A.M., hemoptysis (coughing up blood) noted. Resident said it just started happening in the last hour or two. Staff sent chest x-ray (CXR) results and signs/symptoms to physician along with most recent lab results and allergies. Staff received new order to transfer resident to the hospital emergency department (ED) for CT scan (computed tomography - medical imaging to view internal images of the body). Resident declined transfer stating he/she would rather avoid the stay in the waiting room if possible. Physician was notified and new orders received for STAT (urgent) CT of chest with contrast, decrease Eliquis (anti-platelet medication) from 5 milligrams (mg) BID (twice daily) to 2.5 mg BID for three days then back to 5 mg BID, STAT CBC (complete metabolic count - blood count) and BMP (basic metablic profile - blood count), start cefepime (antibiotic) 2 gram (g) IV (intravenous - directly in the vein) every 8 hours for 3 days, then omnicef (antibiotic) 300 mg by mouth BID for 4 days, and probiotics (live bacteria and yeasts that have beneficial effects on the body) by mouth BID for 14 days; -On 02/01/24, at 3:32 A.M., staff provided education to resident regarding declining to go to the emergency room and CXR results. Resident verbalized understanding, but continued to decline to go to ED. Resident's vital signs within normal limits and resident denied dyspnea (difficulty breathing) or shortness of breath. Staff noted crackles to bilateral (both sides) lower lungs with nonproductive cough noted with minimal bright red hemoptysis. The nurse attempted to start an IV catheter twice and was unsuccessful; (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	-On 02/01/24, at 5:17 A.M., the Assistant Director of Nursing (ADON) received call from charge nurse. Charge nurse reported abnormal findings of CXR with possible mass or lesion in right lung. Charge nurse reported orders received from provider for emergent transfer to ED for STAT CT with contrast of chest and abdomen. Charge nurse reported resident refused at this time to transfer to ED. ADON requested to speak with resident via phone. ADON voiced concern to resident regarding transfer to ED for further evaluation. ADON discussed with resident at length the possible risks of not transferring to ED. Resident voiced understanding and appreciation and agreed to transfer to ED at this time. Staff will continue to monitor; -On 02/01/24, at 5:35 A.M., ADON notified of resident condition. Resident spoke with nurse and made an informed decision to go to ED as physician previously ordered. Staff notfied physician. Vital signs obtained and oxygen saturation noted to have decreased into the 60%'s with dyspnea and shortness of breath apparent. Supplemental oxygen applied at 2 LPM (liters per minute) and oxygen saturation increased to 91%. Transported to ED via Emergency Medical Services (EMS) transport. Staff notified all parties. Review of the resident's Facility Initiated Transfer showed the following information: -Date of Transfer: 02/01/24 -Date of Notice (initiated on the electronic record system): 02/01/24 -Effective Date (notice printed out and mailed to resident representative): 03/19/24 (47 days after the transfer). During an interview on 07/29/24, at 3:00 P.M., the resident said the facility told him/her about the Bed Hold Policy, but did not remember receiving a transfer letter or notice when he/she went out to the hospital. The resident said his/her spouse never mentioned getting a letter or notice in the mail. 2. Review of Resident #65's face sheet (gives basic profile information) showed the following information: -admitted to the facility on [DATE] and readmitted [DATE]; -Diagnoses included impaired circulatory function, diabetes, anxiety, depression, anemia, atrial fibrillation (a-fib - irregular heart function), coronary artery disease, congestive heart failure (CHF - long-term condition that happens when the heart can't pump blood well enough to give the body a normal supply), high blood pressure, low kidney function, history of blood clot, and respiratory failure. Review of the resident's progress note dated 02/05/24, at 1:07 P.M., showed staff documented the following information: (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	-Resident went unresponsive approximately 11:45 A M. Staff performed sternal rub with no response. Resident was frothy at the mouth. Resident's vitals signs and received the order from the ADON to send to the hospital. Staff called 911, gave them hospital instruction and nature of problems. EMS arrived approximately 11:55 A.M. and left building with resident and paperwork approximately 12:03 P.M. Staff called family member. Review of the resident's Facility Initiated Transfer showed the following information: -Date of Transfer: 02/05/24 -Date of Notice: 02/05/24 -Effective Date: 03/06/24 (30 days after the transfer). Review of the resident's progress notes dated 04/29/24, at 2:53 P.M., showed the following: -Nurse was called into resident's room by a certified nurse aide (CNA) for concerns of blood in stool. Assessment showed copious amounts of blood in the stool with large clots. Nurse spoke with resident's Nurse Practitioner (NP) and orders were placed to send resident to the hospital. Resident voiced understanding. Nurse spoke with resident's family member regarding this and he/she voiced understanding. Staff called report to EMS. Review of the reisdent's Facility Initiated Transfer showed the following information: -Date of Transfer: 04/29/24 -Date of Notice: 04/29/24 -Effective Date: 06/03/24 (35 days after the transfer). 41787 3. Review of Resident #70's face sheet showed the following information: -admitted [DATE]; -Diagnoses included hemiplegia and hemiparesis (partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, repeated falls, cerebrovascular disease (term for conditions that affect blood flow to your brain), and abnormalities of gait and mobility. Review of the resident's progress notes, dated 04/17/24, showed staff documented the following: (continued on next page)

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	-At 2:19 P.M., (late entry) the nurse was informed by staff members that the resident had fallen in his/her room. Upon arriving the nurse found the resident facing recliner lying on the floor on his/her back. The bedside table was at the left side of resident's face. The call light was setting up on bedside table. There were no spills or clutter around foot area noted. The resident was able to explain how fall happened. Nurse noted wounds to left side of face. Nurse assessed resident and helped to the recliner, cleaned the wound, and started neuros checks. Staff notified physician and family notification. -At 2:27 P.M., staff notified physician and family. This nurse was informed by staff members that resident had fallen in his/her room. Upon arriving found the resident faced the recliner lying on the floor on his/her back. The bedside table was at the left side of the resident face with call light up on bedside table. No spills or clutter around foot area noted. Resident able to explain how fall happened and had wounds to left side of face. Staff assessed resident, helped to recliner, cleaned wound, and started neuros. -At 8:11 P.M., staff called NP to report resident's complaint of pain. The resident had no range of motion in his/her knees and he/she stated pain from his/her neck down to legs. Resident had some swelling in both knees and no bruising is present. Staff appplied ice pack to bilateral knees with pain medication administered. Staff waiting for return call at this time; -At 9:56 P.M., NP called and staff gave condition report. Resident complained of pain at base of neck and knees. New order received to transfer the resident to emergency room for CT scan, as resident did hit his/her head. Neuro-checks have been within normal limits; -At 10:32 P.M., resident left to emergency room via ambulance with assist of two staff and family was notified. Review of the resident's Facility Initiated Transfer showed the following information: -Date of Transfer: 04/17/24 -Date of Notice: 04/17/24 -Effective Date: 05/24/24 (37 days after the transfer). During an interview on 07/25/24, at 11:06 A.M., the resident said he/she did not know about a hospital transfer letter when he/she was sent to the hospital. 4. During an interview on 07/26/24, at 10:25 A.M., Licensed Practical Nurse (LPN G) said that he/she would send a resident face sheet, physician orders, current code status, interact form (information form in the computer about the resident's current health). He/she did not know anything about a transfer form to be sent to the families. During an interview on 07/26/24, at 10:35 A.M., Registered Nurse (RN) D said when sending a resident to the hospital the nursing staff send with the EMS a change of condition form, resident face sheet, resident medication list, copy of code status, and hospital transfer form. The nursing staff contacts the family by phone about the transfer. There was no letter or form that nursing staff mailed or completed about the transfer to the resident or family. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 07/26/24, at approximately 10:25 A.M., ADON Q said the following: -Staff does send some paperwork when the resident goes to the hospital; -The assessment, face sheet, orders summary, and a copy of the code status is given to EMS when it is time to transport the resident; -Staff will call the responsible party/next of kin (NOK) and the physician; -Staff only communicate with others by email or phone; -No paperwork is actually sent out of the facility to anyone. During interviews on 07/26/24, at 2:00 P.M., and on 08/02/24, at 9:51 A.M., the Business Office Manager (BOM) said he/she he/she did not mail any other letter to the family regarding transfer to the hospital. The effective date on the notices reflects when someone signed the completed form and sent it out. He/she was the only staff currently overseeing that function. If he/she was not available, the timeframe for sending out the notices was sometimes longer. During an interview on 08/02/24, at 10:56 A.M., the Clinical Nurse Consultant said the BOM had been sending out the transfer notices when a resident was sent out to the hospital. The BOM then confirmed he/she was responsible for completing the notices in the electronic record system. After completion, the form notices were given to the resident and/or mailed to their representative. During an interview on 07/25/24, at 2:42 P.M., the Administrator said they did not do a written transfer letter/notice. The facility sent a log to the Ombudsman on a monthly basis showing transfers. 50185 37358

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to complete the required Preadmission Screening and Resident Review (PASARR - a two level tool used to screen each resident in a nursing facility for mental disorder or intellectual disability prior to admission) prior to or upon admission to the facility for one resident (Resident #14). The facility census was 101. Review of the facility's policy titled Admission Criteria, dated March 2019, showed the following information: -All new admissions and readmissions are screened for mental disorders, intellectual disabilities, or related disorders per the PASARR process; -The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a mental disorders, intellectual disabilities, or related disorders; -If the level I screen indicates that the individual may meet the criteria for a mental disorders, intellectual disabilities, or related disorders, he/she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process; -Upon completion of the Level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he/she needs, and whether placement in the facility is appropriate; -The state PASARR representative provides a copy of the report to the facility; The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation; -Once a decision is made, the state PASARR representative, the potential resident, and his/her representative are notified. 1. Review of Resident #14's face sheet (brief overview of resident information) showed the following information: -admitted [DATE]; -Diagnoses include dysphagia (difficulty swallowing), intellectual disabilities, cognitive communication deficit, visual loss in both eyes, and dementia. Review of the resident's care plan, last revised on 05/12/21, showed the following information: -Required extensive assistance with two staff for toileting, mobility, dressing, and transfers related to intellectual disabilities; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Visual and hearing disablement; -Lacked capacity to understand and make decisions regarding healthcare. Review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 05/25/24, showed the following information: -Resident rarely or never understood; -Substantial to maximum assist from staff for personal care and mobility; -Incontinent of bowel and bladder. Review of the resident's record on 07/23/24, at 2:28 P.M., showed no Level I or II PASARR completed. During observation and interview on 07/25/24, at 12:43 P.M., the MDS Coordinator said she is responsible for PASARR's. Level I PASARR's are completed at the hospital prior to admission to the facility. If the resident comes from home, then the facility will complete it. A Level II is only completed if the resident has had a recent behavioral, psychiatric, or impatient stay at the hospital. If a resident does require a level II, the facility contacts Bock Associates and they will come and complete it for the facility. She does not believe this resident would trigger a Level II. The resident has been at the facility for a long time, so he/she should have a completed PASARR. The MDS Coordinator reviewed the resident's electronic medical record (EMR) and said she could not find one. The MDS Coordinator said the Medical Records Nurse might have record of his/her PASARR in paper form. During an interview on 07/26/24, at 1:42 P.M., the Medical Records Director said they were unable to find the resident's PASARR in the facility's records due to him/her being at the facility so long. During an interview on 07/30/24, at 1:33 P.M., the Director of Nursing (DON) and Administrator said, a PASARR Level I should be completed prior to admission to the facility. If they don't have one, the MDS Nurse is responsible for completing them. The resident hasn't had any behavioral admissions, so they do not believe he/she would require a Level II, but he/she should at least have had a Level I 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** 50185 Based on observation, interview, and record review, the facility failed to ensure all residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene when staff failed to provide peri-care and change urine soaked items for one resident (Resident #42). The facility census was 101. Review of the facility's policy titled Urinary Incontinence- Clinical Protocol, last revised April 2018, showed staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status. Review showed the facility did not provide a policy regarding incontinent care and/or performing incontinent care. 1. Review of the Resident #42's face sheet (brief look at resident information) showed the following information: -admitted [DATE]; -Diagnoses include chronic kidney disease, overactive bladder, muscle wasting and atrophy (loss of muscle tissue, size, and strength), and diabetes mellitus. Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment tool completed by facility staff), dated 06/25/24, showed the following information: -admitted [DATE]; -Cognitively intact; -Dependent on staff for mobility; -Substantial to maximum assistance from staff needed for personal hygiene; -Incontinent of bladder. Review of the resident's care plan, last revised on 07/24/24, showed the following information: -Frequent bladder incontinence; -Staff to check as required for incontinence. Staff to wash, rinse, and dry perineum (sensitive skin between genitals). Staff to change clothing as needed after incontinence episodes; -Staff to monitor for signs and symptoms of infection; -At times resident refused to allow staff to change him/her. Puddles of urine have been under his/her chair and resident remains non-compliant with allowing staff to change him/her. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 07/24/24, at 3:37 P.M., showed the following: -The resident sat in his/her wheelchair in his/her room with the call light on. He/she said they were waiting for staff to return to provide care. -Certified Nursing Assistant (CNA) I entered the room at 3:40 P.M. and said he/she would be performing care as soon as he/she found some help. At 3:48 P.M., CNA I , CNA H, and the Assistant Director Of Nursing (ADON) entered the room. CNA I, CNA H, and ADON donned (put on) gowns. At 3:50 P.M., CNA J knocked on the resident's door and entered with a Hoyer lift (mechanical lift). -CNA I and CNA H donned gloves. CNA I obtained the Hoyer lift and positioned it in front of the resident. CNA I and CNA H both obtained Hoyer sling (sling that goes under the resident and hooks to the lift) straps from under the resident and hooked them up to the lift. CNA I operated the Hoyer lift and lifted the resident into the air, while CNA H guided the resident's legs. While aides were doing so, urine was seen on the resident's wheelchair pad that he/she was sitting on and dripping onto the floor from the point of the resident's wheelchair to the bed. -Once the resident was over the top of the bed, CNA I lowered the lift and resident onto the bed with CNA H guiding. CNA I and CNA H unlatched the Hoyer sling from the lift. The ADON prepped brief and laid it on the bed for the aides and then obtained a towel and began cleaning up urine spill on the floor with his/her shoe. -CNA H and CNA I pulled down the resident's pants and took off the resident's shoes. CNA I and CNA H pulled down the resident's dirty brief and exposed the resident. CNA I doffed (took off) gloves and donned new gloves. CNA I handed wipes to CNA H. CNA H wiped under the resident's pannus (excess skin and fat that hang down from the stomach) and down each side of the residents' inner thighs with the same wipe change. The CNAs did not provide peri-care (washing of genitals and anal area). The resident then rolled toward CNA H and CNA I wiped the resident's bottom three times with one wipe. -With no hand hygiene or glove change, CNA I obtained and placed a clean brief under the resident. The wet Hoyer sling was not changed and remained under the resident. Resident rolled toward CNA I and CNA H, pulled out that side of the resident's brief. Resident rolled back onto his/her back. CNA H and CNA I latch the clean brief around the resident and asked the resident if he/she would like them to change his/her pants. The resident said no. CNA H and CNA I did not tell the resident that his/her pants were urine soaked. CNA I and CNA H pulled the residents pants back up. -CNA H and CNA I doffed gloves. CNA H washed hands and CNA I did not. CNA I obtained the Hoyer lift and put it over the top of the resident. CNA I and CNA H latched the Hoyer sling to the Hoyer lift. CNA I operated the Hoyer lift, while CNA H guided the residents' legs. CNA H locked the resident's wheelchair, and CNA I lowered the Hoyer lift and resident down onto the urine-soaked pad in the wheelchair. Before unhooking the resident from the lift, the surveyor asked the aides if they had checked to see if the pad in the resident's wheelchair was urine-soaked. Both aides did not check and unhooked the Hoyer sling from the lift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/26/24, at 9:39 A.M., CNA/Certified Medication Tech (CMT) F said to provide incontinent care staff must, provide privacy, gather all necessary supplies, and perform hand hygiene and don gloves prior. Staff should let the resident know what they are going to be doing. Staff would cleanse front to back, one side of the privates at a time, then down the middle at the end. One wipe per swipe. At the end of that care, staff may apply barrier cream then put the residents' clothes/brief back on. Staff should wash your hands and don clean gloves before and after care, and anytime they go from a dirty surface to a clean one. It would never be acceptable to not change out soiled clothing/linens. During an interview on 07/26/24, at 9:50 A. M., Licensed Practical Nurse (LPN) G said for incontinent care, he/she expected staff to wash their hands, don gloves, remove any dirty items, take off gloves, wash hands, and don new gloves prior to starting care. After cleansing, staff should change wash their hands, don new gloves, then move onto the resident's backside, one wipe per swipe. It is never acceptable to not change out soiled clothing/linens. During an interview on 07/30/24, at 12:08 P.M., the Admissions Coordinator said that staff should always wash their hands, especially when going from a dirty surface to a clean one. Staff should also not leave a resident in soiled clothing or linens. During an interview on 07/30/24, at 1:33 P.M., the Director of Nursing (DON) and the Administrator said there should be two staff for providing incontinent care. Hand hygiene should be performed, the curtain should be pulled, and staff should explain what they are doing. The staff should don gloves and proceed to performing care. One staff member should assist with getting the resident positioned. The second staff should pull down the resident's brief and obtain three wipes. One wipe per side, and one wipe for the middle, utilizing one wipe per swipe. After that, staff should doff their dirty gloves, perform hand hygiene, and don clean gloves, otherwise everything is contaminated. Staff should make sure all linens and clothing being put back on the resident are clean.

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F 0678

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41787

Based on observation, record review, and interview, the facility failed to ensure that one resident's (Resident #46) code status (type of emergent treatment a person would or would not receive if their heart or breathing were to stop) matched throughout the medical record out of a sample of 27 residents. The facility census was 101.

Review of the facility policy titled Advance Directives, dated [DATE], showed the following information:

-Advance directives will be respected in accordance with state law and facility policy;

-Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so;

-Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members or legal representative, about the existence of any written advance directives;

-Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record;

-The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive;

-The Interdisciplinary Team will conduct ongoing review of the resident's decision-making capacity and communicate significant changes to the resident's legal representative. Such changes will be documented in the care plan and medical record;

-Changes or revocations of a directive must be submitted in writing to the administrator. The care plan team will be informed of such changes so that appropriate changes can be made in the resident assessment and care plan.

1. Review of Resident #46's face sheet (brief information sheet about the resident), current as of [DATE], showed the following:

-admitted on [DATE];

-Diagnoses included cerebral infarction (stroke), altered mental status, chronic obstructive pulmonary disease (COPD - group of lung diseases that block airflow and make it difficult to breathe), chronic respiratory failure with hypoxia (condition that results in the inability to effectively exchange carbon dioxide and oxygen, and induces chronically low oxygen levels or chronically high carbon dioxide levels), and systemic lupus erythematosus (SLE - an autoimmune disease. In this disease, the immune system of the body mistakenly attacks healthy tissue);

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Code status of do not resuscitate (DNR - if a person's heart or breathing stops the healthcare team will not try to restart it). Review of the resident's care plan, last revision on [DATE], showed the following: -Code status is full code (the resident wished to receive cardiopulmonary resuscitation (CPR - an emergency life-saving procedure completed when someone's breathing or heartbeat has stopped); -Staff should make sure that the full code is listed as the resident's code status on the resident profile/face sheet; -Staff should provide opportunity for the resident to discuss feeling and ask questions related to end of life decision as needed; -Staff should review code status with the resident/responsible party quarterly or as needed. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated [DATE], showed resident cognitively intact. Review of the resident's Social Services - Assessment and Note, dated [DATE], showed the following: -Quarterly assessment; -Code status of full code; -Code status care plan if the resident's heart stops beating or the resident stops breathing CPR will be initiated per the resident's/responsible party's wishes; -Check to make sure that full code is listed as the resident's code status on the resident profile/face sheet; -Review code status with the resident/responsible party quarterly and as needed. Review of the resident's physician's order sheet, active as of [DATE], showed an order dated, [DATE], for DNR. During an interview and observation on [DATE], at 3:00 P.M., the resident said that he/she would want CPR started if his/her heart or breathing stopped. The care plan inside the resident's closet door showed resident as full code. During an interview on [DATE], at 3:40 P.M., Certified Nurse Aide (CNA) N said that a resident's code status could be found on the top of the screen in the electronic medical record (EMR) and in the resident's closet care plans. During an interview on [DATE], at 9:05 A.M., CNA B said that resident code status was located in the EMR and in each resident's closet care plan. The information should match. (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], at 9:15 A.M., Certified Medication Technician (CMT) M said staff could locate a resident's code status by looking in the EMR and inside a resident's closet door. He/she said the information should match and thought someone checked that monthly. During an interview on [DATE], at 3:55 P.M., Licensed Practical Nurse (LPN) L said that code status for residents can be found on the resident's face sheet in the EMR, as well as in the resident's closets, and this information should match. During an interview on [DATE], at 10:08 A.M., LPN U said he/she would look in the EMR for a resident's code status. During an interview on [DATE], at 10:25 A.M., LPN G said that resident code status was located in the EMR on the face sheet, medication administration record, and the physician orders. The information was also located inside the resident closets on a posted paper care plan. The information should match. He/she was unsure who audits charts for accuracy. During an interview on [DATE], at 10:35 A.M., Registered Nurse (RN) D said that resident code status could be found in the resident medical record and on the care plan posted in residents' closets. The information should match and he/she thought that social services audited for accuracy. During an interview on [DATE], at 10:15 A.M., the Social Service Director (SSD) said the staff would notify him/her when a code status should be changed in the care plan. He/she did not have access to enter information on the face sheet. He/she thought the Administrator audited the charts. During an interview on [DATE], at 2:08 P.M., the Admission Coordinator said that he/she reviewed initial admission code status with residents. When a resident returned from the hospital the nursing staff reviewed if any changes have been made. The nursing staff should audit to ensure the code status is accurate and matched throughout chart. During an interview on [DATE], at 2:20 P.M., Director of Nursing (DON) said resident code status should match throughout the chart. The admission nurse entered the code status information and then the next day on match back the orders should all be checked. (Match back is the chart audit 24 hours after orders are entered.) The resident's care plan and outside hospital orders should all match. When a resident leaves and returns from the hospital the nurses should ensure and update information and ensure it all matches throughout the record. At times the hospital might make someone a DNR at hospital even though the resident has not signed the DNR form. The closet care plan should be updated and accurate, however, it is a guide. Staff should always verify the electronic record. Usually, social services ensured that charts were accurate when doing the quarterly care plan updates. During an interview on [DATE], at 3:00 P.M., the Administrator said that the admission nurses should enter resident code status and then there is a match back to ensure orders match. Code status audits are done every three months with care plan meetings and in-between as needed. The information can be located on the top banner of the EMR, in physician orders, signed documents, and care plan. Staff should notify nurses changes in care plan or EMR are needed. Any nurse can make changes to the care plan, as well as social services. All resident code status should match through their chart. Social Services Director completes quarterly care plan. Inaccuracies should be caught during match back even on readmission from hospital.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37358 Based on observation, record review, and interview, the facility failed to ensure catheter (a sterile tube inserted into the bladder to drain urine) use per standard of practice when one resident's medical record (Resident #47) failed to have a diagnosis to show why the resident had a catheter. The facility census was 101. Review of the facility policy Catheter Care, Urinary, revised, August 2022, showed the following information: -To prevent urinary catheter associated complications, including urinary tract infections (UTI's) staff will review the resident's care plan to assess for any special needs and review and document the clinical indications for catheter use prior to inserting. 1. Review of Resident #47's face sheet (a brief look at the residents personal, incoming information), showed the following information: -admitted [DATE] -Diagnoses included kidney complications. Review of the resident's progress note dated 05/22/24, at 5:18 P.M., showed the resident arrived to facility with a catheter in place. (Staff did not document the diagnosis that warranted the catheter use.) Review of the resident's admissions Minimum Data Set (MDS- a federally mandated assessment tool filled out by facility staff), dated 05/31/24, showed the following information: -Cognitively moderately impaired; -Resident required a catheter; -Diagnoses showed resident has had UTI's. (The MDS did not show a diagnosis associated with need of a catheter.) Review of the resident's physician's orders, dated 07/07/24, showed the following information: -An order, dated 05/26/24, for Foley catheter output documented every shift for health maintenance. (The order did not include the diagnosis that warranted the catheter use.) -An order, dated 06/03/24, for foley catheter to be changed 22nd of every month and as needed. (The order did not include the diagnosis that warranted the catheter use.) (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 06/03/24, for Foley cath care every shift and as needed. (The order did not include the diagnosis that warranted the catheter use.) Review of the resident's care plan, dated 07/07/24, showed the following information: -The resident had an indwelling catheter; -The resident will be/remain free from catheter-related trauma; -The resident will show no signs or symptoms of urinary infection; -Monitor and document intake and output as per facility policy; -Monitor for signs and symptoms of discomfort on urination and frequency; -Monitor/document for pain/discomfort due to catheter. (Staff did not care plan the diagnosis that warranted the catheter use.) Review of the resident's July 2024 Treatment Administration Record (TAR) showed staff did not document the diagnosis that warranted the catheter use. Review of the resident's progress note dated 07/22/23, at 10:19 A.M. showed catheter changed per physician orders. (Staff did not document the diagnosis that warranted the catheter use.) During an interview on 07/30/24, at 11:15 A.M., the Infection Control Nurse said there should be a diagnosis as to why a resident would require a catheter. Someone should have questioned why there was no diagnosis for the catheter. During an interview on 07/30/24, at 1:35 P.M., the Admissions Coordinator said the following: -He/she usually made sure the diagnoses are included in the physician's orders; -A resident requiring a catheter should definitely have a diagnosis as to why they would need it. During an interview on 07/30/24, at 2:10 P.M., the Director of Nursing (DON) and Administrator said the following: -There should be a diagnosis for why the resident would need a catheter; -This is important because physician orders come from diagnosis' and must be followed. 41787

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on observation, interview, and record review, the facility failed to ensure respiratory care consistent with standards of practice when staff failed to obtain a physician's order for staff to administer continuous positive airway pressure machine (CPAP - machine used to deliver constant and steady air pressure while sleeping) for the treatment for obstructive sleep apnea (breathing repeatedly stops and starts during sleep) at bedtime as care planned for one resident (Resident #49) with a CPAP machine at bedside. The facility census was 101. Review of the facility policy titled CPAP Support, dated March 2015, showed the following information: -Purpose to provide the spontaneously breathing resident with continuous airway pressure machine with or without supplemental oxygen; to improve oxygenation in residents with respiratory insufficiency, obstructive sleep apnea or restrictive/obstructive lung disease; and to promote resident comfort and safety; -Review the physician's order to determine the oxygen concentration and the pressure for the CPAP machine; -Review and follow the manufacturer's instructions for CPAP machine setup and oxygen delivery; -Document in the resident's medical record the time CPAP therapy was started and the duration of therapy; the mode and settings for the CPAP; and how the resident tolerated the treatment. 1. Review of Resident #49's face sheet showed the following: -admitted [DATE]; -Diagnoses included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), acquired absence of right leg and left leg above the knee (limb was amputated), congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), and chronic respiratory failure a with hypoxia (condition not have enough oxygen in the tissues in the body). Review of the resident's significant change Minimum Data Set (MDS - a federally mandated comprehensive assessment completed by facility staff), dated 07/07/24, showed the following: -Cognitively intact; -Use of supplemental oxygen; -Staff did not mark use of CPAP treatment. Review of the resident's care plan, last reviewed 07/18/24, showed the following: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had altered respiratory status/difficulty breathing related to sleep apnea; -Staff should apply auto titrating CPAP at 9-15 cwp (centimeters of water pressure (setting to be ordered by the physician)) with heated humidifier; -Staff should monitor, document, and report abnormal breathing pattern to the physician. Review of the resident's June 2024 and July 2024 Treatment Administration Record (TAR) and Medication Administration Record (MAR) showed no order for CPAP placement, pressure setting, or monitoring. Review of the resident's physician order sheet, current as of 07/26/24, showed no order for application or use of CPAP therapy at bedtime. During observation and interview on 07/23/24, at 11:14 A.M., showed the resident's CPAP was on the bedside table. The resident said that the CPAP mask was not always applied by staff at night or machine turned on. The resident said he/she falls asleep and forgets to tell the staff and did not want to bother staff. He/she said that he/she would use the CPAP if staff helped him/her at night. During an interview on 07/25/24, at 3:45 P.M., Licensed Practical Nurse (LPN) L said that CPAP treatment would populate on the nursing TAR during the night shift. The resident did not want his/her CPAP on at night. He/she thought the resident's family took the CPAP out of the room. During an interview on 07/26/24, at 10:08 A.M., LPN U said that the nursing TAR showed what treatments are required for each resident during the shift. He/she did not know if CPAP was on the TAR. During an interview on 07/26/24, at 10:35 A.M., Registered Nurse (RN) D said that treatments and medications populate on the MAR and TAR for each resident. He/she would expect there was an order for a resident with CPAP therapy. During an interview on 07/26/24, at 2:20 P.M., the Director of Nursing (DON) said that the nurses are responsible for CPAP treatment for residents and there should be an order for use. The CPAP should be in the care plan and there should be an order for nurses to apply the CPAP including the pressure settings. The nurses could communicate with aides for CPAP application. During an interview on 07/26/24, at 3:00 P.M., the Administrator said there should be an order for all treatments, including CPAP therapy. The nurses were responsible to ensure the CPAP was started for the resident.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on observation, record review, and interview, the staff failed to ensure correct installation and maintenance of all bed rails when the bed rails of one resident (Resident #49) could be moved by the resident back and forth several inches in each direction. The facility had a census of 101. Review showed the facility failed to provide a policy regarding side rail use, installation, and monitoring. 1. Review of Resident #49's face sheet showed the following: -admitted [DATE]; -Diagnoses included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar (glucose)), dependence on wheelchair, acquired absence of right leg and left leg above the knee (limb was amputated), chronic kidney disease (CKD - kidneys are damaged and can't filter blood the way they should), congestive heart failure (CHF - condition in which the heart can't pump enough blood to the body's other organs), chronic respiratory failure a with hypoxia (condition not have enough oxygen in the tissues in the body), and obstructive and reflux uropathy (urine cannot drain through the urinary tract, and may back up into the kidneys). Review of the resident's significant change in status Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/07/24, showed the following: -Cognitively intact; -Required substantial to maximal assistance with showering/bathing; -Dependent on staff for transfers. Review of the resident's care plan, last reviewed 07/18/24, showed the following: -The resident had an activities of daily living (ADL) self-care performance deficit related to bilateral above the knee amputation; -The resident had enable bars (side rails) to left upper and right upper sides of bed to increase bed mobility and assist with positioning during staff assisted ADLs due to bilateral below the knee amputations; -The resident was informed of risks and benefits of enable bars and consent form signed by resident; -Side rail assessment performed to ensure appropriateness of halo bars for resident; (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Side rail zone measurements every monthly and with every significant change; -Assessment of side rail use dated 4/4/23. Observation and interview on 07/25/24, at 10:53 A.M., showed the following: -The resident seated upright in bed with bilateral (both sides) half side rails on the bed; -The resident said that the right-side rail was very loose and that he/she used the bed rail throughout the day to move him/herself in the bed; -The resident grabbed the right-side rail and pulled with the rail several inches back and forth and side to side when he/she pulled on the rail. The resident said that he/she had notified staff of the rail being this loose. During an interview on 07/26/24, at 11:10 A.M., the Maintenance Director said the following: -He installed enabler bars when notified that therapy had done an evaluation. He checked the measurements, ensured they are installed tightly and securely, and educated the resident on the use of the bar. He checked monthly to ensure nothing was loose or broken; -He visually inspected all bed rails every month, but did not keep a log of this check. -Staff should notify maintenance of items in need of repair or write on the maintenance log at the nursing station. During an interview on 07/26/24, at 2:20 P.M., Director of Nursing (DON) said the following: -Side rail assessments should be reviewed by all management teams; -The maintenance staff should monitor for measurements and safety quarterly or when changes in resident condition; -Staff should notify maintenance if there is something wrong with the bed rail so it can be fixed quickly. During an interview on 07/26/24, at 11:46 A.M., the Administrator said that the Maintenance Director was given a list of all side rails once per month to ensure they were intact and not loose. There was nothing other than a check mark for this check. All items should be repaired any time found or notified loose. Staff should notify maintenance of any needed repairs or damage.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, record review, and interview, the facility failed to ensure that the medication error rate was not 5 percent or greater when the facility failed to prime (removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly) an insulin pen for one resident (Resident #74) and when staff crushed and mixed three medications and administered via percutaneous endoscopic gastrostomy (PEG - a tube that is surgically placed into the stomach through a small incision in the abdomen) for one resident (Resident #254). This resulted in four errors out of 28 opportunities during the observed during medication pass resulting in a 14% error rate. The facility census was 101. 1. Review of manufacturer's instructions regarding NovoLog (rapid acting insulin) FlexPens, last revised on March 2008, showed the pen should be primed before each injection. The pen should be primed by the following steps: -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, 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 there is not a drop of insulin after six times, do not use the pen. Review of Resident #74's face sheet (brief look at resident information) showed the following information: -admitted [DATE] -Diagnoses include type two diabetes, obesity, dependency on renal dialysis (procedure that removes wastes and excess fluid from the blood when the kidneys are no longer able to do so), high blood pressure, and heart failure. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/04/24, showed the following information: -Cognitively intact; -Insulin injections received seven days a week. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, last revised on 04/12/22, showed the resident to receive diabetic medications as ordered by the doctor. Staff to monitor and document any side effects and/or effectiveness. Review of the resident's physician order sheet, dated 07/30/24, showed the following: -Novolog FlexPen Subcutaneous Solution Pen - injector 100 units (U)/milliliter (ml). Administer insulin subcutaneously (under the skin) before meals per sliding scale; -If blood sugar is 181 milligrams (mg)/ deciliter (dL) to 200 mg/dL, administer 2 units of insulin; -If blood sugar is 201 mg/dL to 250 mg/dL, administer 4 units of insulin; -If blood sugar is 251 mg/dL to 300 mg/dL, administer 6 units of insulin; -If blood sugar is 301 mg/dL to 350 mg/dL, administer 8 units of insulin; -If blood sugar is 351 mg/dL to 400 mg/dL, administer 10 units of insulin; -If blood sugar is 401 mg/dL or higher, administer 2 units of insulin. Observation on 07/29/24, at 11:52 A.M., showed Licensed Practical Nurse (LPN) T performed an accucheck (finger stick blood test to determine level of sugar) with the result of 206 mg/dL. The LPN said the resident required 4 units of sliding scale Novolog. He/she wiped the insulin pen with an alcohol swab and attached the needle. Without first priming the insulin pen, the LPN set the dial to 4 and administered the insulin to the resident. During an interview on 07/29/24, at 1:40 P.M., LPN T said he/she only primes the insulin pens for the first initial use,. He/she does not prime insulin pens otherwise. During an interview on 07/30/24, at 12:08 P.M., the Admissions Coordinator said insulin pens should be primed with at least two to four units prior to each administration. During an interview on 07/30/24, at 1:33 P.M., the Director of Nursing (DON) and Administrator said the expectation of staff is to prime the insulin pens prior to each administration. 2. Review of the facility's policy Administering Medications through an Enteral Tube, dated November 2018, showed the following information: -Verify there is a physician's medication order for this procedure; -Review the resident's care plan to assess for any special needs; -Administer each medication separately and flush between medications; -Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy; (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Tablets that must be crushed prior to administration through an enteral tube require a specific order related to crushing. Review of Resident #254's face sheet showed the following information: -admitted [DATE]; -Diagnoses include chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), respiratory failure, encephalopathy (brain disease that alters brain function or structure), and dysphagia (difficulty swallowing). Review of the resident's quarterly MDS, dated [DATE], showed the following information: -Cognitively intact; -51% of calories received are through parenteral (administered or occurring elsewhere in the body than the mouth) or tube feeding; -Takes antianxiety (medications that are used to treat anxiety disorders), antidepressants (medications that are used to treat depressive disorders), anticoagulants (medications that prevent and treat blood clots), opioids (pain reducing medications), and hypoglycemics (a group of drugs that help lower blood sugar levels). Review of the resident's care plan, last revised on 07/24/24, showed the resident has a nothing by mouth (NPO) status with medications and feedings of formula and water enterally. Review of the resident's Physician Order Sheet (POS), dated 07/30/24, showed the following: -Diltiazem (antihypertensive drug that treats high blood pressure) HCI (added salt to help the medication dissolve or be absorbed in the bloodstream) 90 mg tablet, give one tablet via g-tube three times a day; -Gabapentin (anticonvulsant that treats pain and nerve pain and seizures) 100 mg capsule, give one capsule via peg-tube three times a day; -Oxycodone (narcotic that treats moderate to severe pain) HCI 5 mg tablet, give one tablet via peg-tube every four hours as needed. (There was not an order for staff to administer combine medications when administering by the peg-tube.) Observation on 07/24/24, at 1:09 P.M., showed LPN T obtained diltiazem from the medication card, crushed it, then placed it into a medication cup. LPN T obtained gabapentin from the medication card and emptied the capsule into the same medication cup with the diltiazem. LPN T obtained oxycodone from the medication card, crushed it, then placed the medication into the same medication cup with the diltiazem and gabapentin. All medications emptied into a bigger cup and LPN T added 30 ml's of water into the cup and poured it into the resident's peg-tubing via a 60 milliliter (ml) syringe. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/26/24, at 9:50 A. M., LPN G said the expectation for administering medications through a peg-tub would be to crush the medications, pour them together, add water, and administer. There should be a physician order to crush the medications and mix them. LPN G looked in the resident's electronic medical record (EMR) and said the resident did not have an order for this. In the case of not having an order, he/she would first flush the peg-tube with water, keep the medications in separate cups, administer one medication, flush again, and repeat the process until all medications are given. During an interview on 07/26/24, at 9:39 A.M., Certified Nursing Assistant/Medication Technician (CNA/CMT) F said some medications can be crushed and/or mixed while others cannot. Staff must obtain a physician's order to be able to crush or mix any medications. During an interview on 07/30/24, at 12:08 P.M., the Admissions Coordinator said she believes there are standing orders to crush medications for by mouth administrations. If the administration is through a peg tube, that order should be in the record. During an interview on 07/25/24, at 12:37 P.M., the DON said the resident's doctor does not have any standing orders. Staff must call the physician for all orders. During an interview on 07/30/24, at 1:08 P.M., the Medical Director said he does not have any standing orders. The staff must call him for any orders needed. He expected staff to follow his orders and they need to clear it with him before they mix any medications together to administer. During an interview on 07/30/24, at 1:33 P.M., the DON and Administrator agreed that the expectation and best practice for medication administration through a peg-tube would be to flush with water, give one medication, then flush again. That process was to be continued until all medications were administered. There should be a physician's order if the staff were giving medications any other way.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, record review, and interview, the facility staff failed to ensure all resident's were free from significant medication errors when staff failed to prime (removing the air from the needle and cartridge that may collect during normal use and ensures the pen is working correctly, failure to do so may result in giving the resident too much or too little insulin) an insulin pen for one resident (Resident #74). The facility census was 101. Review of manufacturer's instructions regarding NovoLog (rapid acting insulin) FlexPens, last revised on March 2008, showed the pen should be primed before each injection. The pen should be primed by the following steps: -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, 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 there is not a drop of insulin after six times, do not use the pen. 1. Review of Resident #74's face sheet (brief look at resident information) showed the following information: -admitted [DATE] -Diagnoses include type two diabetes, obesity, dependency on renal dialysis (procedure that removes wastes and excess fluid from the blood when the kidneys are no longer able to do so), high blood pressure, and heart failure. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 07/04/24, showed the following information: -Cognitively intact; -Insulin injections received seven days a week. Review of the resident's care plan, last revised on 04/12/22, showed the resident to receive diabetic medications as ordered by the doctor. Staff to monitor and document any side effects and/or effectiveness. Review of the resident's physician order sheet, dated 07/30/24, showed the following: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Novolog FlexPen Subcutaneous Solution Pen - injector 100 units (U)/milliliter (ml). Administer insulin subcutaneously (under the skin) before meals per sliding scale; -If blood sugar is 181 milligrams (mg)/ deciliter (dL) to 200 mg/dL, administer 2 units of insulin; -If blood sugar is 201 mg/dL to 250 mg/dL, administer 4 units of insulin; -If blood sugar is 251 mg/dL to 300 mg/dL, administer 6 units of insulin; -If blood sugar is 301 mg/dL to 350 mg/dL, administer 8 units of insulin; -If blood sugar is 351 mg/dL to 400 mg/dL, administer 10 units of insulin; -If blood sugar is 401 mg/dL or higher, administer 2 units of insulin. Observation on 07/29/24, at 11:52 A.M., showed Licensed Practical Nurse (LPN) T performed an accucheck (fingerstick blood test to determine level of sugar) with the result of 206 mg/dL. The LPN said the resident required 4 units of sliding scale Novolog. He/she wiped the insulin pen with an alcohol swab and attached the needle. Without first priming the insulin pen, the LPN set the dial to 4 and administered the insulin to the resident. During an interview on 07/29/24, at 1:40 P.M., LPN T said he/she only primes the insulin pens for the first initial use,. He/she does not prime insulin pens otherwise. During an interview on 07/30/24, at 12:08 P.M., the Admissions Coordinator said insulin pens should be primed with at least two to four units prior to each administration. During an interview on 07/30/24, at 1:33 P.M., the Director of Nursing (DON) and Administrator said the expectation of staff is to prime the insulin pens prior to each administration.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
James River Nursing and Rehabilitation	3550 East Battlefield Springfield, MO 65809

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on observation and interview, the facility failed to properly store all drugs in locked compartments when three medication carts were observed unlocked while unattended by staff. The facility census was 101. Review showed the facility did not provide a policy pertaining to storage of medication. 1. Observation on 07/26/24, at 11:30 A.M., showed Licensed Practical Nurse (LPN) U positioned a medication cart in the hallway outside a resident's room. The cart was facing the resident's doorway and adjacent wall, approximately two feet away. The LPN dispensed the resident's medications, did not lock the cart, and entered the resident's room to administer the medications. The Assistant Director of Nursing (ADON) R approached the cart and depressed the lock. Observation on 07/29/24, at 1:42 P.M., showed a medication cart positioned with its back against the half-wall of the nurses' station, facing a resident lounge area. Two unidentified residents were in the lounge area, and two staff passed down the hall pushing residents in wheelchairs. The cart was not attended by staff and was not locked. The Director of Nursing (DON) approached the cart and depressed the lock. Observation on 07/24/24, at 1:02 P.M., showed a medication cart positioned against the wall facing toward resident room [ROOM NUMBER] and left unattended. The medication cart contained several cards of medication. Several residents and staff, including housekeeping and LPN T passed by the cart. At 1:04 P.M., Certified Mediation Technician (CMT) V came out of room [ROOM NUMBER] and locked the medication cart. During an interview on 07/26/24, at 9:39 A.M., Certified Nursing Assistant/ Certified Medication Technician (CNA/CMT) F said that medication carts should be locked when staff are not present. During an interview on 07/30/24, at 12:15 P.M. the Admissions Nurse said all medication carts should be locked when staff is walking away from them. During an interview on 07/30/24, at 1:33 P.M., with the Administrator, Director of Nursing (DON), Clinical Nurse Consultant, and Director of Operations, the DON said staff should lock the medication carts when they are not with the cart. 50185

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37358 Based on observation, interview, and record review, the facility failed to follow standards of practice and keep food safe from potential contamination or bacterial growth when staff failed to ensure cups and glasses were air dried before being stored. The facility census was 101. Review showed the facility did not provide a policy regarding drying of dishes. Record review of the 1999 Food Code, issued by the Food and Drug Administration, showed the following information: -After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food; -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. 1. Observations on 07/23/24, at 8:46 A.M., showed 53 small water and juice cups/glasses stored/stacked upside down on a the tray in a manner that trapped water and did not allow for airflow for drying. Observations on 07/26/24, at 11:55 P.M., showed 49 small water and juice cups/glasses stored/stacked upside down on a the tray in a manner that trapped water and did not allow for airflow for drying. During an interview on 07/29/24, at 2:40 P.M., Dietary Aide (DA) W said the following: -He/she was not aware that the dishes had to be dried before they could be stacked/placed upside down trapping water; -he/she was told glasses must be completely dry before putting them away. During an interview on 07/29/24, at 2:50 P.M., DA X said the following: -He/she was told dishes could not be stored away while still wet; -He/she said they were told that it can cause bacteria to grow. During an interview on 07/29/24, at 3:00 P.M., the Dietary Manager (DM) said he/she was not aware that drinking glasses were being placed upside down in a manner that trapped water and prevented air drying. During an interview on 07/29/24, at 2:40 P.M., the Administrator said the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Staff have looked for a policy regarding air drying dishes before storing, but are unable to locate anything related; ought liners that they thought would work to line the trays; -He/she did not realize there was not enough of an air gap to allow for airflow and drying.

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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** 50185 Based on observation, interview, and record review, the facility staff failed to maintain proper infection control when administering medication for two residents (Residents #254 and #8) and failed to properly disinfect glucometers (medical device for determining glucose in the blood) during tests performed for three residents (Residents #74, #22, and #14). The facility census was 101. 1. Review of the facility policy titled Administering Oral Medications, dated October 2010, showed staff should not touch medications with their hands. Review of Resident #254's face sheet (gives basic profile information), showed the following information: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe), respiratory failure, encephalopathy (brain disease that alters brain function or structure), and dysphagia (difficulty swallowing). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment completed by facility staff), dated 06/08/24, showed the following information: -Cognitively intact; -Takes antianxiety (medications that are used to treat anxiety disorders), antidepressants (medications that are used to treat depressive disorders), anticoagulants (medications that prevent and treat blood clots), opioids (pain reducing medications), and hypoglycemics (a group of drugs that help lower blood sugar levels). Review of the resident's physician order sheet, dated 07/30/24, showed the following: -Diltiazem (antihypertensive drug that treats high blood pressure) HCl (added salt to help the medication dissolve or be absorbed in the bloodstream) 90 milligram (mg) tablet, give one tablet via g-tube (tube used for medication nutrition when resident cannot do so by mouth) three times a day; -Gabapentin (anticonvulsant that treats pain and nerve pain and seizures) 100 mg capsule, give one capsule via peg-tube (g-tube) three times a day; -Oxycodone (narcotic that treats moderate to severe pain) HCl 5 mg tablet, give one tablet via peg-tube every four hours as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/24/24, at 1:09 P.M., showed Licensed Practical Nurse (LPN) T obtained diltiazem from the medication card, crushed it, then placed it into a medication cup. LPN T obtained gabapentin from the medication card and emptied the capsule into the same medication cup as diltiazem. LPN T obtained oxycodone from the medication card, crushed it, then placed the medication into the same medication cup as the diltiazem and gabapentin. LPN T emptied all medications into a bigger cup and added 30 milliliters (ml) of water into the cup. After adding water to the cup LPN swirled the medication. The medication continued to have some clumping of medications. LPN T took his/her gloved finger and stirred the medications. LPN T apologized and said he/she did not have a spoon with him/her. LPN T then poured the medications into the resident's peg-tubing via a 60 ml syringe. During an interview on 07/26/24, at 9:39 A.M., Certified Nursing Assistant/Medication Technician (CNA/CMT) F said it was not acceptable to stir medications with one's fingers, gloved or not. During an interview on 07/26/24, at 9:50 A.M., LPN G said that he/she would not stick his/her finger in medications to stir them. The expectation is to use a spoon. He/she would consider stirring medications with a finger, gloved or not as cross contamination and an infection control issue. During an interview on 07/30/24, at 12:08 P.M., the Admissions Coordinator said it is not acceptable to stir medications with one's finger, gloved or not. During an interview on 07/30/24, at 1:33 P.M., the Director of Nursing (DON) and Administrator said it would not be acceptable for staff to stir medications with their fingers. 2. Review of Resident #8's face sheet showed the following: -admitted [DATE]; -Diagnoses included anemia, congestive heart failure (CHF - inability for heart to pump blood to the body as needed), renal insufficiency (kidney issues), pain, dementia, high cholesterol, and thyroid disorder. Review of the resident's significant change MDS, dated [DATE], showed the following: -Severely impaired cognition; -Received antipsychotic and antiplatelet (helps prevent blood clots) medications on a routine basis. Review of the resident's care plan, last updated 07/24/24, showed the following: -Resident has congestive heart failure. Administer cardiac medications as ordered; -Resident has impaired cognitive function/dementia or impaired thought processes. Administer medications as ordered; -Resident uses psychotropic medication. Administer psychotropic medications as ordered by physician; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident has chronic pain. Anticipate the resident's need for pain relief; -Resident has chronic renal failure related to kidney disease stage 3. Administer medications as ordered by physician. Observation on 07/29/24, at 9:18 A.M., showed CMT M the following: -The CMT used hand sanitizer before preparing the resident's medications; -The CMT punched medications from bubble packed cards into a medication cup: -The CMT dispensed medications from bottles by pouring pill into the lid and then into the medication cup: -The CMT entered the resident's room and placed the medication cup on top of a tapestry runner covering a dresser. The cup tipped over, spilling out multiple pills. The CMT used a plastic spoon to scoop the pills up and put them back into the cup and said, At least they didn't hit the floor. The CMT gave the cup of pills to the resident with a drink. During an interview on 07/30/24, at 1:33 P.M., with the Administrator, DON, Clinical Nurse Consultant, and Corporate Director of Operations, the DON said staff should follow all infection control guidelines. They should discard dropped pills and re-dispense them. 3. Review of the undated manufacturer's manual titled Glucocard, the glucometer used, showed the following disinfecting procedures: -Wear appropriate protective gear such as disposable gloves; -Open the cap of the disinfectant container and pull out one towelette and close the cap; -Wipe the entire surface of the glucometer three times horizontally and three times vertically using a new towelette to remove blood borne pathogens; -Dispose of the used towelettes in the trash; -Allow exteriors to remain wet for the corresponding contact time for each disinfectant; -After disinfection, the users gloves should be removed to be thrown away and hands washed before proceeding to the next patient. 4. Review of Resident #74's face sheet showed the following information: -admitted [DATE]; -Diagnoses include type two diabetes. Review of the resident's current care plan showed the resident to receive diabetic medications and fasting blood glucose levels as ordered by the doctor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's quarterly MDS, dated [DATE], showed the resident was cognitively intact and resident received insulin injections seven days a week. Observation on 07/29/24, at 11:56 A.M., showed LPN T completed another resident's accucheck and placed the glucometer into a sani-wipe (without wiping or thoroughly wetting the glucometer) and placed the glucometer onto medication cart next to a second wrapped glucometer. LPN T sanitized his/her hands, donned gloves, obtained a test strip and placed it into the 2nd glucometer that he/she obtained from the top of the medication cart that had been wrapped in a sani-wipe. LPN T obtained an alcohol wipe and prepped the resident's finger. LPN T obtained a lancet, obtained blood from the resident's finger, and placed it onto the test strip. LPN T obtained a sani-wipe from its container and wrapped the glucometer (without wiping or thoroughly wetting the glucometer) and placed it on the medication cart. 31464 5. Review of Resident #22's face sheet showed the following: -admitted [DATE]; -Diagnoses included diabetes mellitus. Review of the resident's significant change MDS, dated [DATE], showed resident's cognition intact and received insulin on seven of the previous seven days. Review of the resident care plan, last updated 07/23/24, showed the following information: -At risk for pain related to disease process; -Resident had diabetes mellitus. Staff to obtain fasting blood sugar as ordered by doctor. Observation on 07/26/24, at 11:40 A.M., showed LPN V used hand sanitizer and prepared supplies to perform an accucheck for the resident. LPN V unwrapped glucometer #2 (the same machine used to complete the previous accucheck for the previous). The LPN did not wipe the machine with a sani-cloth and did not allow time for the machine to air dry, and completed the Accucheck. 6. Review of Resident #14's face sheet showed the following: -admitted [DATE]; -Diagnoses included diabetes mellitus. Review of the resident's quarterly MDS, dated [DATE], showed resident had severely impaired cognition and received insulin on seven of the previous seven days. Review of the resident's care plan, last updated 05/25/24, showed resident had diabetes mellitus and staff to obtain fasting serum blood sugar as ordered by doctor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 07/26/24, at 12:12 P.M., showed LPN G used hand sanitizer and donned gloves to perform an accucheck for the resident. LPN G wrapped the glucometer in a sani-wipe without first wiping it clean and placed the machine on top of the treatment cart. 7. During an interview on 07/29/24, at 1:40 P.M., LPN T said upon finishing an accucheck, he/she wrapped the glucometer in a sani-wipe and let it sit for five minutes, after that, the glucometer is sanitized and he/she goes on using it. 8, During an interview on 07/30/24, at 12:08 P.M., the Admissions Coordinator said glucometers should be sanitized with sanitizing wipes. The glucometers must actually be wiped down and then let dry before they are considered sanitized. 9. During an interview on 07/30/24, at 1:33 P.M., with the Administrator, DON, Clinical Nurse Consultant, and Corporate Director of Operations, the DON said staff should follow all infection control guidelines. 41787