STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265749	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodland Manor	1347 East Valley Watermill Road Springfield, MO 65803

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on observation, interview, and record review, the facility failed to maintain a complete infection prevention and control program when the facility failed to develop a policy regarding enhanced barrier precautions (EBP - precautions for use during high-contact resident care activities for residents infected with a multidrug-resistant organism (MDRO - microorganisms that are resistant to one or more classes of antimicrobial agents) or any resident who has a chronic wound and/or indwelling medical device), failed to train staff on EBP, failed to have personal protective equipment (PPE) and signage present for residents that met the guidelines for EBP, and failed to ensure staff wore PPE in accordance with the Centers for Disease Control (CDC) guidelines for three or three residents (Residents #1, #2 and #3) who met the guidelines for EBP. A sample of nine residents were reviewed in a facility with a census of 83. Review of the CDC's Implementation of Personal Protective Equipment Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms, dated 07/12/22, showed the following: -MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs; -EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities; -EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status, and infection or colonization with an MDRO; -Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care; -EBP use of PPE refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing; (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Examples of high-contact resident care activities requiring gown and glove use for EBP includes dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use such as central line, urinary catheter (flexible tubing that is used to drain urine from the bladder), feeding tube, and tracheostomy/ventilator, and wound care on any skin opening requiring a dressing; -Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE. For EBP signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves; -Make PPE, including gowns and gloves, available immediately outside of the resident room. Review showed the facility did not provide a policy that addressed Enhanced Barrier Precautions. Review of the facility's policy titled Infection Control Policy, revised September 2022, showed the following; -Transmission-based precautions are additional measures that protect staff, visitors, and other residents from becoming infected; -When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance and on the front of the charge so that personnel and visitors are aware of the need for and the type or precaution; -The signage informs the staff of the type of CDC precautions, instructions for use of PPE, and/or instructions to see a nurse before entering the room. Review of the facility documents show the facility has six residents with foley catheters (medical device that helps drain urine from the bladder), eight residents with pressure wounds, and six residents with non-pressure wounds. 1. Review of Resident #1's face sheet showed the following: -admitted [DATE]; -Diagnoses included quadriplegia and colostomy (opening in the abdomen to divert the large intestines, colon, to the outside of the body). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 04/30/24, showed the following: -Dependent upon staff for toileting and personal hygiene; -Indwelling catheter (collects urine by attaching to a drainage bag). Review of the resident's care plan, dated 03/13/24, showed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Access the drainage every shift, record amount, type, color, odor, and observe for leakage for suprapubic (through a hole in abdomen and then directly into the bladder) catheter; -Stage four pressure injury (extend to muscle, tendon or bone) on sacrum (triangle bone at base of spine), anterior (found towards the front of the body) perianal and right ischial (the right and left sides of your pelvis); -Cleanse sacral wound with pure and clean (cleansing for wounds). Use 4 X 4 gauze soaked with pure and clean to gently wipe inside wound bed. Pat wound bed with dry 4 X 4 s. Moisten kerlex (pre-moistened washcloths) with pure and clean, gently pack wound bed. Place calcium alginate (dressing for a wound) over ulcer to distal right ischial. Cover with 4 X 4 s, then ABD pads (gauze pads used to absorb discharged from wounds) secure with medipore tape. (Staff did not care plan related to EBP.) Review of the resident's June 2024 Physician's Order Sheet (POS), showed the following: -An order, dated 02/04/24, for suprapubic catheter; -An order, dated 02/04/24, to provide catheter care each shift; -An order, dated 02/04/24, to change foley catheter as needed for leaking or blockage; -An order, dated 02/04/24, to change colostomy wafer and bag as needed for leaking; -An order, dated 02/06/24, for treatment of perianal wound, right ischial wound and sacrum wound. Observations and interviews on 06/14/24, at 8:48 A.M. and 2:15 P.M., showed the following: -No signage on the front of the resident's door indicating resident on EBP; -No PPE outside or inside of the resident's room; -Resident lying on his/her bed with catheter on the side of his/her bed; -Resident said the staff take care of his/her catheter and they wear gloves only. 2. Review of Resident #2's face sheet showed the following: -admitted [DATE]; -Diagnoses included multiple sclerosis (condition that affects brain and spinal cord) and quadriplegia (paralysis of the body). Review of the resident's care plan, dated 05/05/24, showed the following: -Resident has an indwelling catheter related to urine retention; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff will change catheter as ordered and monitor intake/output. Review of the resident's admission assessment MDS, dated [DATE], showed the following: -Cognitively intact; -Resident had impairment on both sides of the body; -Resident is dependent for toileting hygiene, shower, and required substantial assist with personal hygiene; -Resident had indwelling catheter. Review of the resident's June 2024 POS showed the following: -An order, dated 04/16/24, for suprapubic catheter; -An order, dated 04/19/24, to flush suprapubic catheter two times per day; -An order, dated 04/19/24, to record intake and output every shift; -An order, dated 05/03/24, to change supra pubic catheter one time monthly. Observation on 06/14/24, at 8:15 A.M., showed the following: -No signage on the front of the resident's door indicating resident on EBP; -No PPE inside or outside of the resident's room; -Two staff in the resident's room, not wearing personal protective equipment (PPE), with a shower table where they had brought resident back to his/her room after a shower. Observation and interview on 06/14/24, at 11:58 A.M., showed the following: -The resident in his/her wheelchair, with a catheter bag at the side; -No PPE inside or outside of the resident's room; -He/she knows staff provide catheter care and empty his/her bag, however, he/she doesn't know what PPE the staff wear except he/she does feel gloves on his/her skin when care is provided. 3. Review of Resident #3's face sheet showed the following: -admitted [DATE]; -Diagnoses included chronic kidney disease, retention of urine, and cognitive communication deficit. (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 care plan, dated 03/13/24, showed the following: -Resident required indwelling urinary catheter in place related to urine retention; -Staff will change catheter as directed. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderately impaired cognition; -Resident requires partial assistance with toileting hygiene and supervision with personal hygiene; -Resident has indwelling catheter. Review of the resident's June 2024 POS showed the following: -An order, dated 02/20/24, for foley catheter; -An order, dated 02/20/24, to provide catheter care each shift; -An order, dated 02/20/24, to change foley catheter as needed for leaking and blockage; -An order, dated 02/20/24 to irrigate foley catheter every shift for sediment as needed. Observations and interviews on 06/14/24, at 2:15 P.M. showed the following: -No signage on the front of the resident's door indicating resident on EBP; -No PPE inside or outside of the resident's room; -Resident lying in his/her bed with the catheter bag hanging on the side of his/her bed; -Resident didn't think staff wore gloves or gown when providing catheter care. 4. During an interview on 06/14/24, at 12:05 P.M., Certified Medication Technician (CMT) A said he/she doesn't remember what EBP is and doesn't know what PPE should be used when a resident is on EBP. 5. During an interview on 06/14/24, at 12:14 P.M., Licensed Practical Nurse (LPN) B said residents on EBP would have a sign and report, as well as PPE in a cart outside of the door. 6. During an interview on 06/14/24, at 1:13 P.M., Registered Nurse (RN) C said he/she had heard about EBP. Staff wear gloves when providing catheter care. He/she isn't aware of any other requirements. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 06/14/24, at 1:25 P.M., Certified Nurse Aide (CNA) D said when he/she provides catheter care for residents he/she wears gloves and no other PPE. He/she isn't sure about EBP. He/she knows there are signs on residents' doors when they have a transmittable disease and the PPE containers. 8. During an interview on 06/14/24, at 1:36 P.M., CNA E said he/she isn't sure about EBP. When he/she provides catheter care, he/she wears gloves only. 9. During an interview on 06/14/24, at 1:53 P.M., the Assistant Director of Nursing (ADON) said the following: -They haven't put procedures in place for the EBP; -The Infection Preventionist (IP)/Director of Nursing (DON) is working on this; -At this time there isn't notification of resident's on EBP; -At this time there is no additional PPE required for residents on EBP; -When staff are providing catheter care they are required to wear gloves. 10. During an interview on 06/14/24, at 2:23 P.M., CNA F said the following: -He/she wasn't aware of EBP until today; -He/she wears gloves only when providing catheter care to residents. 11. During an interview on 06/17/24, at 8:55 A.M., LPN G said the following: -He/she had never heard about EBP until today; -He/she and staff wear gloves when performing catheter care; -Residents do not have signage for EBP, but they do when they're on transmission based precautions, as well as PPE outside of the door. 12. During an interview on 06/14/24, at 2:55 P.M., Administrator and DON/IP said the following: -Staff do not currently know when residents are on EBP; -In considering the EBP staff should be wearing gloves, gown, goggles, and masks when providing catheter care; -He/she will be working on implementing enhanced barrier precautions. MO00235341