STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265836	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nodaway Healthcare	22371 State Highway 46 Maryville, MO 64468

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 - Few	Provide and implement an infection prevention and control program. 40141 Based on observation, interview, record review, and facility policy review, the facility failed to ensure nebulizer tubing and a nebulizer mouthpiece were cleaned after use and stored in a manner to prevent potential contamination between uses for 1 (Resident #22) of 1 resident reviewed for respiratory care. Findings included: A facility policy titled, Departmental (Respiratory Therapy)- Prevention of Infection, revised 11/2011, specified, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. The section of the policy addressing, Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol indicated, 3. After completion of therapy: a. Remove the nebulizer container; b. Rinse the container with fresh tap water; and c. Dry on a clean paper towel or gauze sponge. 4. Reconnect to the administration set-up when air dried. 5. Take care not to contaminate internal nebulizer tubes. 6. Wipe the mouthpiece with damp paper towel or gauze sponge. 7. Store the circuit in plastic bag, marked with date and resident's name, between uses. An Admission Record indicated the facility admitted Resident #22 on 06/02/2022. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, dyspnea (difficult or labored breathing), and mild intermittent asthma. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/19/2024, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #22's care plan included a focus area, initiated on 07/23/2024, that indicated the resident had altered respiratory status/difficulty breathing related to chronic obstructive pulmonary disease and anxiety. An intervention dated 07/23/2024 directed staff to administer medication/puffers as ordered. Resident #22's Order Summary Report, listing active orders as of 10/08/2024, included an order dated 10/31/2023 for ipratropium-albuterol (a nebulizer solution) 0.5-2.5 milligrams per 3 milliliter vial, one nebulizer treatment every day prior to breakfast related to DYSPNEA. The Order Summary report did not include any orders related to cleaning or storage of the resident's nebulizer tubing or mouthpiece. (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
	265836	A. Building B. Wing	10/10/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #22's Nurse Medication Administration Record for 10/2024 revealed the resident was scheduled to receive their ipratropium-albuterol nebulizer treatment each day at 7:30 AM. According to the Nurse Medication Administration Record, Certified Medication Technician (CMT) #4 signed as having administered the resident's nebulizer treatment on the morning of 10/07/2024, and Licensed Practical Nurse (LPN) #10 signed as having administered the resident's nebulizer treatment on 10/09/2024. During a concurrent interview and observation on 10/07/2024 at 10:40 AM, Resident #22 stated they received a nebulizer treatment earlier in the morning. The resident's nebulizer still had the tubing and mouthpiece attached, and the mouthpiece was observed on the bedding of an extra bed in the resident's room. During an observation on 10/07/2024 at 1:15 PM, Resident #22's nebulizer still had the tubing and mouthpiece attached, and the mouthpiece remained directly on the extra bed in the resident's room. During a concurrent interview and observation on 10/07/2024 at 3:21 PM, LPN #9 said CMT #4 administered Resident #22's medications on the morning of 10/07/2024. LPN #9 stated that after a nebulizer treatment was administered, the tubing and mouthpiece should be disconnected, then cleaned and allowed to air dry. During the interview, Resident #22's nebulizer still had the tubing and mouthpiece attached, and the mouthpiece remained directly on the extra bed in the resident's room. During an interview on 10/09/2024 at 1:58 PM, CMT #4 said that after a nebulizer treatment was complete, the tubing and mouthpiece should be disconnected, cleaned, allowed to air dry, then reconnected and hooked to a latch on the side of the nebulizer machine. CMT #4 said Resident #4's nebulizer mouthpiece should not have been on the bed, but she forgot to clean it. During a concurrent observation and interview on 10/09/2024 at 10:25 AM, Resident #22's nebulizer machine was on the resident's bed with the tubing and mouthpiece attached, resting directly on the bedding. Resident #22 said they had completed their nebulizer treatment, but the nurse had not been back in the room. During an interview on 10/09/2024 at 11:30 AM, LPN #10 said she administered Resident #22's nebulizer treatment before breakfast but had not been back to the resident's room. LPN #10 said the nebulizer tubing and mouthpiece should be cleaned, then stored inside a cubby hole on the nebulizer machine. During an interview on 10/10/2024 at 1:35 PM, the Regional Nurse indicated that following a nebulizer treatment, the nebulizer equipment should be cleaned and placed on a towel to dry to prevent potential infections. The Regional Nurse said Resident #22's nebulizer mouthpiece should not have been on the bed in the resident's room. During an interview on 10/10/2024 at 2:17 PM, the Administrator stated nebulizer mouthpieces should not be placed on residents' beds; they should be cleaned and put away.