STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265160	A. BUILDING _____ B. WING _____	**09/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEWIS & CLARK GARDENS	**1221 BOONES LICK ROAD SAINT CHARLES, MO 63301**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain good personal hygiene for three residents (Residents #1, #2 and #3), who resided on the isolation hall (hallway utilized for residents who tested positive for Coronavirus Disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome COVID-19 infection), in a review of 11 sampled residents. The facility census was 86. Review of the facility's policy, Bath (Shower), dated March 2015, showed the following: -Encourage the resident to do as much of his/her own care as possible; supervise and assist as necessary; -Wash face, shampoo hair and rinse well; -Wash upper extremities and body; -Wash lower extremities and feet; -Wash perineal area; -Rinse resident well; -Dress resident; -Transfer resident to bed or wheelchair, comb and style hair. Review of the facility's policy, A.M. Care (Early Morning Cares), dated March 2015, showed to allow resident to brush teeth, or brush teeth or dentures for the resident if he/she is not able. Review of the facility's policy, Shaving the Resident, dated March 2015, showed staff were to remove facial hair and improve the resident's appearance and morale. 1. Review of Resident #3's care plan, last revised 9/20/19, showed staff were to assess the resident's grooming and dressing needs and one staff member was to provide assistance. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 6/8/20, showed the following: -Cognitively intact; -Required supervision from one staff with bed mobility and transfers; -Required limited assistance from one staff with dressing and personal hygiene; -Required extensive assistance from one staff with toileting; -Required extensive assistance from one staff with bathing; -Frequently incontinent of bowel and bladder. During an interview on 9/24/20 at 3:24 P.M., the administrator said the resident tested positive for COVID-19 infection on 9/11/20 and was moved to the isolation hall. Observation on 9/17/20 at 2:55 P.M., showed the resident sat in a wheelchair in his/her room, located on the isolation hallway. The resident was barefoot and wore a gown snapped only at the nape of his/her neck. The resident's incontinence brief was visible from the side as the gown was in disarray and separated in the back. His/Her hair was disheveled and oily. The resident was unshaven with stubble over his/her face. During an interview on 9/17/20 at 3:00 P.M., the resident said the following: -Staff did not assist him/her with dressing; -He/She wore a night gown every day, and he/she was cold; -He/She had not received a shower for about 10 days, when he/she was on the regular hall; -He/She loved having a routine shower; -He/She hated it on this hall, he/she said, felt like a second class citizen; -He/She did not have a comb or a tooth brush and didn't know where his/her shoes and socks were located. 2. Review of Resident #2's quarterly MDS assessment, dated 8/20/20, showed the following: -Made self-understood and understood others; -Moderate cognitive impairment; -Required setup/supervision of one staff with bed mobility, transfers, dressing, and personal hygiene; -Required physical assistance from one staff with bathing; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised 8/20/20, showed the following: -The resident required encouragement and assistance with showers; -Provide setup or supervision for activities of daily living (ADLs) as needed. During an interview on 9/24/20 at 3:24 P.M., the administrator said the resident tested positive for COVID-19 infection and was moved to the isolation hall on 8/29/20. Observation on 9/17/20 at 3:05 P.M., showed the resident sat on the side of the bed in his/her room, located on the isolation hallway. The resident wore a bathrobe and slip on shoes without socks. The resident's hair was disheveled. Review of the resident's bathing documentation showed no evidence a shower had been completed in at least a month. During an interview on 9/17/20 at 3:08 P.M., the resident said he/she was always in his/her robe and had not showered in 16 days. He/She did not know if he/she had a way to clean or brush his/her teeth. He/She was very frustrated and would like to be dressed in warm clothes. He/She could not wait to get off of this hall and back to his/her regular room. 3. Review of Resident #1's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Independent with bed mobility, transfers, toileting and personal hygiene; -Required extensive assistance from one staff with bathing; -Occasionally incontinent of urine; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised 7/17/20, showed staff was to assess the resident's grooming and dressing needs and provide assistance of one staff member. Review of the resident's nurse's note dated 8/28/20 at 9:25 P.M., showed resident was moved to the COVID isolation unit following a positive test result. During an interview on 9/17/20 at 1:40 P.M., the resident said the following: -Staff recently moved him/her back to a regular room (not on the isolation hall); -He/She was on the isolation hall for a couple weeks; -He/She did not have clothes to wear when he/she was on the isolation hall, and went without incontinence briefs when he/she was in isolation; -He/She did not receive a shower when on the isolation hall; -He/She was angry he/she had to go through that experience. He/She read an inspirational book and tried to keep his/her mind occupied. 4. During an interview on 9/17/20 at 2:40 P.M. and 10/14/20 at 9:15 A.M., Certified Nurse Assistant (CNA) B said the following: -He/She worked on the isolation hall from 6:00 A.M. to 2:00 P.M.; -Initially, the facility only had one or two COVID-19 positive residents and the CNA on the isolation hall would give the residents showers. Once the number of residents increased (currently nine residents), showers were missed. He/She thought it was a staff miscommunication and showers were not completed; -He/She tried to make his/her own shower list and pass it on to the charge nurse, but he/she did not think the showers got completed; -The spa room was more accessible (easier to use) for residents and had grab bars, however, the spa/shower room was blocked off by a plastic partition and the residents on the isolation hall did not have access to it; -He/She missed providing residents with oral care and did not pass out any supplies to the residents. He/She did not know where the toothpaste, toothbrushes and razors were located on the isolation hall, so those things did not get done; -He/She knew where the items were located on the other halls, but staff who worked on the isolation hall were not allowed to enter the other halls if they were working with COVID-19 positive residents; -Most of the residents' personal items were left in their regular room. During interviews on 9/17/20 at 2:45 P.M. and 3:20 P.M., CNA A said the following: -He/She did not routinely work on the isolation hall, however, he/she was assigned to work on the isolation hall today from 2:00 P.M. to 10:00 P.M.; -He/She did not know if there was a list of residents who were to receive a shower or if he/she was to complete any showers on his/her shift; -He/She could not locate a toothbrush or toothpaste in Resident #2 or Resident #3's room. -He/She was not sure why the residents on this hall did not have have toothbrush or toothpaste. During an interview on 9/17/20 at 4:00 P.M., Registered Nurse (RN) Infection Preventionist said the following: -He/She worked on the isolation hall routinely for the past week; -He/She thought the Director of Nursing (DON) or Assistant Director of Nursing (ADON) communicated to the CNAs on the isolation hall which residents were scheduled for a shower each day, he/she did not have a shower list; -Residents should have oral care each day and should be dressed if their preference; -He/She was not aware the residents did not have a toothbrush or toothpaste in their rooms. During an interview on 10/7/20 at 1:06 P.M., the ADON said the following: -The facility did not have a system in place for staff to document when showers were completed, however, staff were to document when showers were given in the electronic health record under bathing; -She did not inform

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

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.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) staff of when residents were to receive showers; -The CNA assigned to a hall was responsible for giving showers; -The charge nurse was responsible for reporting if residents received or did not receive a shower. During an interview on 9/24/20 at 11:20 A.M., the DON said the following: -She expected staff to assist the residents with showers and shaving routinely, and to dress the residents daily; -She felt once the residents were moved to the isolation hall, a breakdown in communication occurred; -The charge nurse on the isolation hall should make a list of residents who were to receive showers and be responsible for ensuring the CNAs completed the showers; -The ADON and DON were not responsible for making the list of residents who needed a shower on the isolation hall; -Staff were to pass out toothbrushes, toothpaste and other hygiene items to all of the residents on the isolation hall. The items had been placed in a cabinet in the activities/temporary nurse's station area on the isolation hall. The items were not labeled and staff did not know where they were located. During an interview on 9/29/20 at 3:30 P.M., the administrator said the facility had no documentation to show the CNAs completed showers on any of the residents for approximately a month. He expected staff to document the showers.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff washed or sanitized their hands after each direct resident contact and where indicated by professional standards of practice during medication administration for three additional sampled residents (Residents #9, #10 and #11). The facility census was 86. Review of the Nurse Assistant in a Long-Term Care Facility manual, 2001 revision, showed the following: -Handwashing is the single most important means of preventing the spread of infections; -Wash hands before and after contact with residents; -Always wash hands for at least 15 seconds before and after glove use. Review of the Infection Control Guidelines for Long Term Care Facilities, January 2005 edition, Section 3.0, Body Substance Precautions, Subsection 3.2 Implementing the Body Substance Precautions System, showed the following regarding gloves and handwashing: -Instructions should be followed by ALL personnel at all times regardless of the resident's diagnosis; -Gloves: Wear gloves when it can be reasonably anticipated that hands will be in contact with mucous membranes, non-intact skin, any moist body substances (blood, urine, feces, wound drainage, oral secretions, sputum, vomitus, or items/surfaces soiled with these substances); gloves must be changed between residents and between contacts with different body sites of the same resident; -REMEMBER: Gloves are not a cure-all; they should reduce the likelihood of contaminating the hands, but gloves cannot prevent penetrating injuries due to needles or sharp objects; dirty gloves are worse than dirty hands because microorganisms adhere to the surface of a glove easier than to the skin on your hands; and handling medical equipment and devices with contaminated gloves is not acceptable; -Handwashing: Handwashing remains the single most effective means of preventing disease transmission; wash hands often and well, paying particular attention to around and under fingernails and between the fingers; wash hands whenever they are soiled with body substances, before food preparation, before eating, after using the toilet, before performing invasive procedures and when each resident's care is completed. Review of the facility's policy, Handwashing, dated March 2015, showed the purpose of handwashing was to reduce transmission of organisms from resident to resident, nursing staff to resident, and resident to nursing staff. Review of the facility's policy, Hand Cleanser (Antiseptic), dated March 2015, showed the purpose was to cleanse the hands between resident contacts during care and to prevent spread of infection. Place the container of antiseptic solution on the medication cart or in a secure area not accessible to residents. Wash and dry hands thoroughly in preparation for resident care. Administer medication. Apply recommended amount of antiseptic cleanser into the palm of the hand. Rub hands briskly until cleanser has evaporated. 1. Review of Resident #9's Physician order [REDACTED]. Observation on 9/17/20 at 12:41 P.M., showed the following: -Certified Medication Technician (CMT) A exited the resident's room, walked to the medication cart and retrieved the medication cart keys from his/her pocket; -No hand sanitizer was observed on the medication cart; -Without sanitizing his/her hands, he/she placed Risperadone 15 mg, [MEDICATION NAME] 800 mg, and [MEDICATION NAME] 0.25 mg in a medication cup; -He/She donned (put on) gloves without washing or sanitizing his/her hands, entered the resident's room, and administered the medications to the resident; -CMT A removed his/her gloves, did not wash or sanitize his/her hands, exited the resident's room, returned to the medication cart and documented administration of the medications in the electronic health record. 2. Review of Resident #10's POS, dated 9/6/20 through 10/6/20, showed the following: -[MEDICATION NAME] (medication to treat shakiness or stiffness) 10/100 mg three times daily (TID); -Boost (nutritional supplement) 60 cubic centimeters (cc). Observation on 9/17/20 at 12:43 P.M., showed the following: -After administering medications to Resident #9, CMT A retrieved the medication cart keys from his/her pocket and unlocked the medication cart; -Without washing or sanitizing his/her hands, he/she poured Boost supplement from the carton and placed the [MEDICATION NAME] in a medication cup; -Without sanitizing his/her hands, he/she donned gloves and entered Resident #10's room; -He/She administered the medications to the resident, removed his/her gloves, and without washing his/her hands, exited the resident's room; -He/She returned to the medication cart, touched the computer mouse and charted on the electronic health record; -He/She then retrieved a new medication cup for the next resident. 3. Review of Resident #11's POS, dated 9/6/20 through 10/6/20, showed the following: -Vitamin B-12 (vitamin)1000 micrograms daily; -[MEDICATION NAME] (gut [MEDICATION NAME])10 mg four times a day (QID); -[MEDICATION NAME] (pain medication) 300 mg TID; -Magnesium Oxide (supplement) 400 mg daily; -[MEDICATION NAME] (blood pressure medication) 5 mg TID; -[MEDICATION NAME] (pain medication) 10/325 mg QID; -Trazadone (antidepressant)150 mg two times a day (BID). Observation on 9/17/20 at 12:46 P.M., showed the following: -After administering medications to Resident #10, CMT A, without washing or sanitizing his/her hands, placed Resident #11's medications (Vitamin B-12, [MEDICATION NAME], Magnesium Oxide, [MEDICATION NAME] and Trazadone) in a medication cup; -He/She poured a cup of water, and without washing or sanitizing his/her hands, donned gloves; -He/She entered the resident's room and then exited the room with gloves on to retrieve a spoon and pudding from the medication cart; -He/She re-entered the room wearing the same gloves and administered the medications to the resident; -He/She removed his/her gloves, and without washing his/her hands, he/she exited the room. 4. During an interview on 10/6/20 at 3:16 P.M., CMT A said he/she should wash or sanitize his/her hands before preparing medications, before entering a resident's room, before exiting a resident's room and between administering medications to different residents. If he/she did not wash or sanitize his/her hands they would be soiled and he/she would contaminate the items he/she touched. During an interview on 10/7/20 at 2:45 P.M., the director of nursing said staff should sanitize their hands before pulling the medications from the cart, upon entering a resident's room, and between administering medications to different residents. Staff should either sanitize or wash their hands before exiting a resident's room. If staff wear gloves, they should wash their hands after removing their gloves. He/She expected hand sanitizer to be kept on the medication cart.
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective resident call system on the isolation hall (hallway utilized for residents who tested positive for Coronavirus Disease 2019 (COVID-19, an infectious disease caused by severe acute respiratory syndrome COVID-19 infection), for two sampled residents (Residents #1 and #3), in a review of 11 sampled residents, so activation of the call light system was communicated directly to the staff working on the hall. Nine residents were located in rooms on the isolation hall. The facility census was 86. Review of the facility's policy, Call Light Use, dated March 2020, showed the following: -All facility personnel must be aware of call lights at all times; -Answer all lights promptly whether or not you are assigned to the resident; -For bedside call lights, a light and/or sound will appear and be heard over the door of the resident's room and on the board at the nursing station; -Answer all call lights in a prompt, calm, courteous manner; -Never make the resident feel you are too busy to give assistance, offer further assistance before you leave the room; -Check the call light system at regular intervals. 1. Observation on 9/17/20 at 2:35 P.M., showed the following: -The isolation hall was separated from other areas of the building, including other hallways and the nurses' station that would normally serve this hallway, with plastic partitions (floor to ceiling and wall to wall plastic partitions) that hung across the entrances to the isolation hall; -The call light panel for the isolation hall was located at the nurses' station, however, staff on the isolation hall did not have access to this area due to the plastic partition that hung across the hallway preventing access; -The staff entrance to the isolation hall was located at the end of the hallway opposite the nurses' station; -The staff entrance led directly from the outside and into an activities room, staff on the isolation hall were using as a temporary nursing station; -A plastic

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F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) partition hung across the hallway between the activities room and the isolation hall; -A second plastic partition hung across the hallway just after the first partition in order to create a transition area between the two partitions where staff put on and removed their personal protective equipment (PPE) before entering and exiting the isolation hall from the activities room/temporary nurses' station; -Three staff who were working on the isolation hall were in the activities room at the end of the isolation hall behind two plastic partitions. No other staff were observed working on the isolation hall; -Staff could not visualize the hall from the temporary nurses' station. 2. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 6/8/20, showed the following: -Cognitively intact; -Required supervision of one staff with bed mobility and transfers; -Required limited assistance from one staff with dressing and personal hygiene; -Required extensive assistance from one staff with toileting; -Required extensive assistance from one staff with bathing; -Frequently incontinent of bowel and bladder. Review of the resident's care plan, last revised on 9/21/20, showed the following: -Keep call light in reach. Remind the resident to call for assistance; -Encourage the resident to use his/he call light when he/she wants to get out of bed. Also, check on the resident frequently if rested and ready to get out of bed; -The resident fell on [DATE]. Make sure the resident's call light is within reach at all times. Encourage use of call light for assistance when transfers and when needing to use the bathroom During an interview on 9/17/20 at 3:00 P.M., the resident said the following: -He/She routinely waited 30 minutes to an hour for his/her call light to be answered on the isolation hall; -Staff did not come to assist him/her with cares; -He/She hated it on this hall. He/she said, felt like a second class citizen. 3. Review of Resident #1's quarterly MDS, dated [DATE], showed the following: -Cognitively intact; -Independent with bed mobility, transfers, toileting and personal hygiene; -Required extensive assistance from one staff with bathing; -Occasionally incontinent of urine; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last revised 7/17/20, showed the following: -The resident had a physical functioning deficit. Ensure call light is within reach with cues and reminders to use; -The resident was at risk for falls due to weakness related to [MEDICAL TREATMENT]. Encourage the resident to verbalize when feeling more weak than usual so staff can assist and monitor the resident closer; -Staff to assess the resident's grooming and dressing needs and provide assistance of one staff member. During an interview on 9/17/20 at 1:40 P.M., the resident said the following: -He/She had to wait hours for staff to answer his/her call light when he/she was on the isolation hall; -He/She would turn his/her call light on, because he/she needed medications, or needed incontinence briefs, so he/she could get changed after incontinence; -He/She lay wet in urine waiting for staff to answer his/her call light. It made him/her feel terrible; -He/She was angry he/she had to go through this and felt he/she was not cared for on the isolation hall. 4. Observations on the isolation hall (300 hall) on 9/17/20, showed the following: -At 3:05 P.M., the call light in room [ROOM NUMBER] lit up in the hallway. There was no audible signal noted on the isolation hall to alert staff of the resident's call light. The staff working on the isolation hall were in the activities room behind the plastic partitions; -At 3:20 P.M., the call light in room [ROOM NUMBER] lit up in the hallway. There was no audible signal noted on the isolation hall to alert staff of the activated call light. 5. During interviews on 9/17/20 at 2:40 P.M. and 10/14/20 at 9:15 A.M., Certified Nurse Assistant (CNA) B said he/she worked on the isolation hall 6:00 A.M. to 3:00 P.M. Staff could hear the call light audible signal at certain times of the day; however, if there were other noises (such as birds outside in the early morning), it was hard to hear the call lights. During interviews on 9/17/20 at 2:45 P.M. and 3:20 P.M., CNA A said he/she could not hear the call light audible signal when he/she was at the temporary nurses' station (activities room at the end of the isolation hall). The lights sounded at the opposite end of the hall (behind a plastic wall partition), so the staff had to watch for the lights. During an interview on 9/17/20 at 4:20 P.M., Registered Nurse (RN)/Infection Preventionist said the following: -He/She routinely worked on the isolation hall for the past week; -He/She thought staff could hear the call lights; however, he/she could not hear the call lights at their temporary nurses' station; -The call light panel was at the opposite end of the hall behind a plastic partition. During an interview on 9/24/20 at 11:20 A.M., the Director of Nursing (DON) said the following: -She did not know staff on the isolation hall could not hear the call lights because of the plastic partition at the end of the hall; -The plastic partition blocked off the nurses' station where the call light panel was located, and where the lights were audible to staff.