STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265849	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCKNIGHT PLACE EXTENDED CARE	TWO MCKNIGHT PLACE SAINT LOUIS, MO 63124

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure care plans were updated to reflect the residents' current needs by not including falls, the use and monitoring of anticoagulants, a cardiac pacemaker, a chest drain, compression stockings, [MED]gen therapy, orthotic devices, nutritional needs and long term care status for five of 14 sampled residents (Residents #33, #7, #49, #31 and #39). The census was 56. 1. Review of Resident #33's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/16/19, showed the following: -Moderately impaired cognitive skills; -Limited assistance of staff for most activities of daily living (ADL's); -One fall with major injury; -[DIAGNOSES REDACTED]. Review of the resident's incident progress notes, showed the following: -7/[DATE]9, 3:09 P.M., late entry, spoke with daughter regarding resident's recent hospitalization and stated he/she told her and spouse that he/she had fallen while going to the restroom the night before going to the hospital on [DATE]. He/she had frequent falls while living in an apartment and would not tell anyone right away, to remain independent. He/she is stubborn and the daughter is aware of the resident refusing assistance, medications and therapy; -8/23/19, 10:24 P.M., notified by certified nurse's aide (CNA) that resident said he/she slipped out of chair when getting up to go to bed. Upon entering room for an assessment, the resident was sitting on the side of the bed waiting. Alert and oriented times three, call light and walker within reach. The resident stated he/she was getting up from the recliner to go to bed and slid down. Active range of motion and passive range of motion within normal limits for the resident with no pain presenting, suprapubic catheter intact. Abrasion measuring 3 centimeters (cm) long by 1 cm wide to right buttock and 4 cm long by 1 cm wide abrasion to back of right side, trace bleeding present, cleaned and dressed. No other injuries presenting at this time; -9/22/19, 5:45 P.M., CNA found resident lying supine on floor in front of recliner, walker was on top of him/her, stated got up from bed, using a two wheeled walker and while taking a few steps forward, lost balance and fell backwards, no apparent injuries noted, denied pain and stated did not hit head; -9/30/19, 1:30 A.M., resident had a fall around 11:15 P.M., not witnessed. Stated hit head on wheelchair going from the restroom, got a scratch 2 cm long and a bruise 2 cm by 1 cm, denies pain, will continue to monitor; -10/9/19, 4:59 A.M., staff member heard a noise outside the resident's room and found the resident sitting on buttocks on the floor with knees bent up towards his/her chest. The nurse did a full body assessment with no injury found. The resident reported no pain and there was nothing in the area for the resident to hit his/her head on, stated he/she did not hit his/her head. Review of the resident's care plan, updated 10/23/19, showed the following: -Focus, fall with no injury, poor balance, unsteady gait, poor safety awareness. 5/5/19 fall without injury, 5/6/19 fall without injury; -Goals, will resume usual activities without further incident through next review date; -Interventions, for no apparent acute injury, determine and address causative factors of the fall, non skid socks on when in bed, pharmacy consult to evaluate medications, physical therapy consult for strength and mobility, re-educated on call light. During an interview on [DATE] at 9:30 A.M., the Director of Nursing (DON) said any nurse and the MDS coordinators can update care plans. When a resident has a fall, the care plan should be updated with new interventions put into place. All falls were discussed at the weekly risk meeting attended by the DON, Assistant Director of Nursing, MDS coordinators, resident care supervisor, administration, social work and therapy. 2. Review of Resident #7's admission MDS, dated [DATE], showed the following: -Mild cognitive impairment; -Extensive assistance of staff required for most ADLs; -[DIAGNOSES REDACTED]. Further review of the resident's medical diagnoses, showed a [DIAGNOSES REDACTED]. Review of the resident's physician's orders [REDACTED].-fib. Repeat [MEDICATION NAME] Time (PTT-evaluates the ability of blood to clot properly, used to help diagnose bleeding) and International Normalized Ratio (INR-used to monitor the effectiveness of blood thinning drugs) on 3/2/20. Review of the resident's care plan, updated on 3/6/20, showed the following: -Focus, here short term for rehab and has little or no activity involvement, related to wishes not to participate; -Goals, will participate in activities of choice; -Interventions, provide a monthly calendar -Anticoagulant use and monitoring of PTT/INR not mentioned; -Cardiac pacemaker not mentioned. During an interview on [DATE] at 1:00 P.M., a facility physical therapist said the resident had been discharged from skilled therapy and was now in the facility for long term care. During an interview on [DATE] at 12:56 P.M., the resident said the device on the table was to check his/her pacemaker, but he/she went to the cardiologist to have it checked about every three months. During an interview on [DATE] at 1:30 P.M., the DON said the resident's care plan should address the use and monitoring of an anticoagulant and a cardiac pacemaker. The device in the resident's room was used for routine checks of the pacemaker. The care plan should be revised to indicate the resident is now in the facility for long term care. 3. Review of Resident #49's admission MDS, dated [DATE], showed the following: -admitted to the facility on [DATE]; -Moderate cognitive impairment; -Extensive assistance required for mobility and personal care; -[DIAGNOSES REDACTED]. Review of the POS [REDACTED]. -An order, dated 1/27/20, to drain the Pleur X catheter every Monday, Wednesday and Friday morning; Review of the care plan, in use during the survey, showed no documentation regarding the Pleur X drain or the use of a blood thinner medication. 4. Review of Resident #31's medical record, showed the following: -[DIAGNOSES REDACTED]. Review of the resident's current POS, showed the following: -TED hose ([MEDICAL CONDITION] disease, elastic hose that compress the superficial veins in the lower limbs.) knee length, apply to both lower extremities daily for [MEDICAL CONDITION] (swelling); -[MED], (anticoagulant) 2.5 mg daily; -Takes anticoagulant. Check each shift for excessive bleeding, bruising, blood tinged or blood in urine, dark stool, severe headache, nausea, vomiting, diarrhea, muscle or joint pain, blurred vision, any changes in mental status or sudden change in vital signs; -Admit Medicare A (skilled services); -May have [MED]gen 2-5 liters for shortness of breath. Review of the resident's care plan updated on 12/18/19, showed the following: -He/she is in the facility for short term stay for rehabilitation; -The use of anticoagulant therapy and monitoring not care planned; -The use of TED hose or [MEDICAL CONDITION] not care planned -The use of [MED]gen not care planned. Observation on 3/5/20 at 11:15 A.M., showed the resident sat in a wheelchair in his/her room. He/she wore TED hose that went up to his/her upper thighs. His/her shorts were half way down his/her legs. He/she said he/she used a [MED]gen concentrator at night. He/she had tried to use a bilevel positive airway pressure ([MEDICAL CONDITION]) (for sleep apnea) machine but it did not work for him/her because the mask was too small and it hurt. Observation on 3/6/20 at 7:02 A.M., showed the resident lay on his/her back in bed. The [MED]gen was on but the cannula was not in his/her nostrils. The concentrator was set at 2 liters. During interviews on [DATE] at 1:29 P.M. and [DATE] at 7:10 A.M., the DON said that the resident's anticoagulant therapy, TED hose and [MED]gen therapy should be on the care plan. He/she is a long term resident now. The care plan should reflect his/her long term status. 5. Review of Resident #39's quarterly MDS, dated [DATE], showed the following: -[DIAGNOSES REDACTED]. Review of the resident's current

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

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) POS, showed the following: -He/she should wear a hip orthotic as tolerated while up in a wheelchair; -Knee separator to be on when up in a wheelchair daily; -An order, dated 7/6/19, for health shakes and ice cream three times a day with meals. Review of the resident's nutrition progress notes, showed the following: -On 1/7/20 at 9:07 A.M., he/she weighed 93.4 pounds (lbs). His/her Ideal body weight range (IBWR) is 90 to 110 lbs. Resident received pureed food with health shakes three times a day (TID). Resident's weight was down 2.6 lbs in 3 months. He/she was on the low end of IBWR. Add ice cream to shakes TID; -On 1/12/20 at 2:16 P.M., he/she received health shakes three times a day for supplement and add ice cream to shakes and give with meals; -On 2/5/20 at 9:29 P.M., he/she received health shakes three times a day for supplement and add ice cream to shakes and give with meals. Review of the resident's weights, showed: -10/3/19, 96.0 lbs; -12/17/19, 92.2 lbs; -1/3/20, 93.4 lbs; -2/4/20, 95.0 lbs; -[DATE], 91.4 lbs. Review of the resident's care plan, updated on [DATE], showed the following: -It did not address the use of the hip orthotic and knee separator; -It did not address the resident's nutritional status or the supplements. During an interview on [DATE] at 1:29 P.M., the DON said the resident's knee abductor and separator should be on the care plan and his/her weight issues and nutrition should be on the care plan as well.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all physician orders [REDACTED].#39), not applying TED hose ([MEDICAL CONDITION] disease, elastic hose that compress the superficial veins in the lower limbs) as ordered for one resident (Resident #31) and not applying lymphadema (swelling) wraps to one resident's lower legs as ordered (Resident #44). The sample size was 14. The census was 56. 1. Review of Resident #39's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed the following: -[DIAGNOSES REDACTED]. Review of the resident's current physician's orders [REDACTED]. Review of the resident's nutrition progress notes, showed the following: -On 1/7/20 at 9:07 A.M., he/she weighed 93.4 pounds (lbs). His/Her ideal body weight range (IBWR) is 90 to 110 lbs. Resident received pureed food with health shakes three times a day (TID). Resident's weight is down 2.6 lbs in 3 months. He/she is on the low end of IBWR. Add ice cream to shakes TID; -On 1/12/20 at 2:16 P.M., he/she received health shakes three times a day for supplement and add ice cream to shakes and give with meals; -On 2/5/20 at 9:29 P.M., he/she received health shakes three times a day for supplement and add ice cream to shakes and give with meals. Review of the resident's weights, showed: -10/3/19, 96.0 lbs; -12/17/19, 92.2 lbs; -1/3/20, 93.4 lbs; -2/4/20, 95.0 lbs; -[DATE], 91.4 lbs. Observation on 3/5/20 at 2:12 P.M., showed the resident lay in bed. There was a sign above his/her bed that read to keep hip abductor device between legs when up in wheelchair. If he/she does not tolerate in the morning, then try again after breakfast. Observation on 3/6/20 at 10:03 A.M., showed the resident received breakfast which consisted of pureed food and a cup with health shake in it. He/she did not receive ice cream with his/her meal. He/she ate approximately 25% of the meal. There was no knee separator or hip abductor in place. At 11:33 A.M., he/she sat in the activity room and leaned to the right with no knee separator or hip abductor in place. At 12:45 P.M., he/she sat in the dining room and was fed by his/her spouse and had no knee separator or hip abductor in place. Observation on [DATE] at 9:13 A.M., showed Certified Nurse Aides (CNA)s C and H assisted the resident out of bed. There were two pads in the resident's wheelchair. They did not place the hip abductor or knee separator for the resident when they positioned him/her in the wheelchair. At 11:00 A.M., he/she sat in the activity room and wore the knee separator but no hip abductor. At 12:34 P.M., he/she sat at the dining room table with his/her spouse. At 1:28 P.M., he/she remained at the table with his/her spouse and did not receive a health shake or ice cream with his/her meal. Review of the March 2020 medication administration record (MAR), showed an order for [REDACTED]. The time for administration was 9:00 A.M., 2:00 P.M., and 9:00 P.M. The MAR showed it was administered from [DATE]-[DATE]. During interviews on [DATE] at 1:29 P.M. and [DATE] at 6:50 A.M., the Director of Nursing (DON) said physician orders [REDACTED]. She would expect it to be charted, if not done, the reason why it was not done, and should not be charted as done if not done. The ice cream should be more dietary and not on the MAR because it is given with meals. 2. Review of Resident #31's medical record, showed the following: -[DIAGNOSES REDACTED]. Review of the resident's current POS, showed the following: -TED hose knee length, apply to both lower extremities daily for [MEDICAL CONDITION] (swelling); -Daily weights before breakfast; -[MED], (anticoagulant) 2.5 milligrams (mg) daily; -Takes anticoagulant. Check each shift for excessive bleeding, bruising, blood tinged or blood in urine, dark stool, severe headache, nausea, vomiting, diarrhea, muscle or joint pain, blurred vision, any changes in mental status or sudden change in vital signs. Observation on 3/5/20 at 11:15 A.M., showed the resident sat in a wheelchair in his/her room. He/she wore TED hose that went up to his/her upper thighs. His/her shorts were half way down his/her legs. Observation on 3/6/20 at 8:35 A.M., showed CNA G got the resident dressed. He/she wore regular midcalf dark socks. CNA G asked him/her which shoes he/she wanted to wear, and he/she said the white ones. His/her lower legs were reddish in color. There were TED hose hanging on the grab bar in the bathroom. At 11:38 A.M. , the resident sat in his/her room in a wheelchair, wore shorts and no TED hose were on his/her legs. At 12:40 P.M., he/she sat in the dining room and no TED hose were on his/her legs. Observation on [DATE] at 9:40 A.M. , showed he/she sat in his/her room. He/she did not wear TED hose. He/she said the TED hose hurt at his/her flexion points like behind his/her knees. He/she had only two pairs of TED hose, and staff had to wash them by hand. If he/she gets to bed earlier enough, his/her [MEDICAL CONDITION] goes down. They have adjusted the [MEDICATION NAME] (medication to reduce fluid) and the [MEDICAL CONDITION] has been a problem. During an interview on [DATE] at 1:29 P.M., the DON said the resident's TED hose should be applied if there is an order. Physician orders [REDACTED]. Review of Resident #44's quarterly MDS, dated [DATE], showed the following: -No cognitive impairment; -Unable to ambulate; -Required extensive assistance of staff for mobility and personal hygiene; -[DIAGNOSES REDACTED]. Review of the POS, showed an order, dated 9/[DATE]8, to apply [MED] (stockings used to provide flexible, multi-layered compression to control swelling) to bilateral lower extremities. Night shift to remove for one hour and for showers. Review of the care plan, dated 11/7/17 and last revised on 8/15/19, showed no documentation regarding the use of [MED]. Observations on 3/5/20 at 10:23 A.M., showed he/she sat in the wheelchair, [MED] not on his/her legs and he/she said that he/she no longer wears the wraps because his/her legs are so much better. Observation on 3/6/20 at 9:06 A.M. and 1:21 P.M. and [DATE] at 7:31 A.M. and 11:11 A.M., showed he/she sat in the wheelchair and [MED] not on his/her legs. Review of the MAR, dated 3/1 through 3/31/20, showed [MED] documented as applied 3/5 through [DATE]. During an interview on [DATE] at 1:30 P.M., the DON said physician's orders [REDACTED]. During a follow up interview on [DATE] at 6:50 A.M., the DON said the resident sometimes refuses the wraps and he/she may only let certain staff apply them. She would not expect staff to chart that they were on if they were not, and she would expect the nurse to document why the wraps were not on. At 7:10 A.M., the DON said the resident refused the wraps and brought in the MAR and progress notes, which showed he/she refused. She said the doctor should be notified if he/she refused the wraps for one month. Review of the progress notes, dated 3/5 through [DATE], showed the following: -3/6/20 at 5:25 A.M., [MED] not worn at night; -3/6/20 at 9:34 A.M., resident declines [MED]; -[DATE] at 8:40 A.M., resident declines [MED]; -[DATE] at 6:00 A.M., [MED] not worn at night. Further review of the MAR, dated 3/1 through 3/31/20, and provided by the DON, showed [MED] documented as applied 3/5 through [DATE].
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the manufacturer's recommendations during three of four resident transfers with a Hoyer lift (mechanical lift used to transfer a resident from one surface to another) observed (Residents #55, #14 and #15). The sample size was 14. The census was 56. Review of the facility's Lifting Machine, Using a Mechanical Lift Policy, dated 2001 and last revised July 2017, showed the following: -Purpose: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. It is not a substitute for manufacturer's training or instruction; -Steps in the Procedure: -1. Before using a lifting device, assess the resident's condition including physical/cognitive and emotional; -2. Measure the resident for proper sling size and purpose, according to manufacturer's instructions; -4. Prepare the environment by clearing an unobstructed path for the

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) lift machine, ensure enough room to pivot, position the lift near the receiving surface and place the lift at the correct height; -10. Place the sling under the resident and visually check the size to ensure it is not too big or too small; -12. Attach sling straps to sling bar, according to manufacturer's instructions; -13. Lift the resident two inches from the surface to check the stability of the attachments, the fit of the sling and the weight distribution; -15. Slowly lift the resident. Only lift as high as necessary to complete the transfer; -16. Gently support the resident as he or she is moved but do NOT support any weight; -17. When the transfer destination is reached, slowly lower the resident to the receiving surface; -19. Detach the sling from the lift. Review of the manufacturer's instructions, included the following: -Positioning the lift: The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the resident and lift the resident off the surface of the bed. When the legs of the lift are no longer under the bed, return the legs of the lift to the maximum open position and lock the shifter handle immediately; -Lifting the Resident: When using the adjustable base lift, the legs MUST be in the open/locked position before lifting the resident. 1. Review of Resident #55's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/10/20, showed the following: -Severe cognitive impairment; -Unable to ambulate; -Extensive assistance required for all care; -Incontinent of bowel and bladder; -[DIAGNOSES REDACTED]. Review of the care plan, dated [DATE], showed no documentation of how the resident transferred. Observation on 3/4/20 at 1:30 P.M., showed the resident sat in his/her room in the wheelchair on a Hoyer sling (large piece of material that cradles the resident during transfer). Certified Nurse's Aides (CNA)s A and B entered the room, spread the legs of the Hoyer lift and wheeled the Hoyer around the wheelchair. After connecting the sling to the lift, CNA A operated the lift and CNA B monitored the resident's position. CNA A lifted the resident approximately two feet above the chair, stepped around and moved the wheelchair, closed the legs of the Hoyer and rolled the lift approximately six feet to the bed. With the legs of the lift closed, the CNAs lowered him/her to the bed and disconnected the sling from the lift. During an interview on 3/4/20 at approximately 1:40 P.M., CNAs A and B said the legs of the lift should only be open around the wheelchair and closed at all other times. 2. Review of Resident #14's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Unable to ambulate; -Dependent on staff for all care except for eating; -Frequently incontinent of bowel and bladder; -[DIAGNOSES REDACTED]. Review of the care plan, dated 5/[DATE]9 and last updated on [DATE], showed no documentation of how the resident transferred. Observation on 3/5/20 at 10:15 A.M., showed the resident sat in his/her room, on a Hoyer sling in the wheelchair. CNAs A and B entered his/her room, spread the legs of the lift around the wheelchair, connected the sling to the lift and raised him/her approximately two feet over the chair. CNA A pulled the lift away from the wheelchair, closed the legs of the lift and rolled it approximately three feet to the bed. With the legs of the lift closed, CNA A lowered the resident to the bed. 3. Review of Resident #15's admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Unable to ambulate; -Extensive assistance required for all care; -Frequently incontinent of bowel; -[DIAGNOSES REDACTED]. Review of the care plan, dated 12/17/19, showed no documentation of how the resident transferred. Observation on 3/5/20 at 11:08 A.M., showed he/she sat in his/her room in the wheelchair on a Hoyer sling. CNA C entered the room with the Hoyer lift and spoke with the resident. CNA C placed the wheelchair directly next to the bed and CNA B entered the room to assist with the transfer. CNA C opened the legs of the lift and wheeled it around the wheelchair, both CNAs connected the sling to the lift and CNA B raised him/her from the chair, pulled the lift away from the chair, closed the legs of the lift and pulled the lift approximately five feet to the center of the room. CNA C moved the wheelchair away from the bed and CNA B rolled the Hoyer to the bed. With the legs of the lift closed, CNA B lowered the resident to the bed. During an interview on 3/5/20 at approximately 11:15 A.M., CNA C said staff should spread the legs of the Hoyer lift around the wheelchair, otherwise the legs should be closed for stability. 4. During interviews on [DATE] at 11:11 A.M. and [DATE] at 1:30 P.M., the Director of Nursing (DON) said with Hoyer lift transfers, there should always be two staff members present. She said the legs of the Hoyer lift should be open for better support, common sense would say to have them open to provide better stability. The policy does not say to have the legs open, but if the manufacturer's guidelines say to open them, they should be. The one Hoyer manufacturer's guidelines may not say it because the lift itself already has a wide base but she would still expect staff to open the legs. The DON said they have a list at the nurse's desk that shows which residents transfer with a Hoyer, however it really should be on each of their care plans.
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** Based on observation, interview and record review, the facility failed to ensure staff followed the facility policy and acceptable professional standards for labeling and discarding [MED] vials and pens. Two of two medication rooms were observed. The facility census was 56. Review of the facility policy for [MED] administration, revised September 2014, showed: -Check expiration if drawing from an unopened multi-dose vial. If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening). Review of the manufacturer's [MED] recommendations, showed: -[MEDICATION NAME](short-acting [MED]) vials expire 28 days after opening. Observation of the Fountain View medication room on 3/5/20 at 10:39 A.M., showed: -One [MEDICATION NAME]vial, dated as opened 1/21/20; -One [MEDICATION NAME] (short-acting) [MED], dated as opened 1/30/20, with a labeled sticker that showed to discard after 28 days; -One [MEDICATION NAME] (long-acting) [MED] vial, opened and not dated; -One [MEDICATION NAME] pen, opened and not dated. Observation of the Magnolia Medication room on 3/5/20 at 10:06 A.M., showed one [MEDICATION NAME] (long-acting) [MED] vial, opened and not dated. During an interview on 3/5/20 at 10:39 A.M. with Licensed Practical Nurse (LPN) A, he/she said that [MED]s expire 30 days after they are opened and should be discarded. During an interview on 3/5/20 at 11:14 A.M., the Director of Nursing (DON) said that all [MED]s should be dated when opened, and the staff should follow manufacturer's recommendations on when to discard.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure staff prepared and served food under sanitary conditions, by not changing gloves and washing hands, touching the surface of plates and utensils with soiled gloved and bare hands, and touching food items with soiled gloved hands. These deficient practices had the potential to affect all residents who ate at the facility. The census was 56. Observation of the kitchen, on 3/5/20 at 6:45 A.M., showed the following: -Dietary Aide (DA) J did not wear gloves and stood at the counter and wiped utensils with a dry cloth before wrapping them in a cloth napkin. DA J's bare hands touched the surfaces of the eating utensils; -Cook K stood behind the steam table, and with gloved hands, reached into a bread bag, removed bread, placed it in the toaster, picked up a pan, went back to the counter and pulled more bread from the bags, walked to the grill and poured pancake batter from a dispenser onto the grill and leaned on the grill with his/her gloved right hand, palm down. The cook continued to touch the bread with the gloved hands while preparing toast; -At 6:50 A.M., DA J used gloved hands to remove mixed fruit from one pan to another. DA J placed gloved fingers inside small bowls, used a scoop in the right hand and placed his/her left gloved hand on top of the fruit and placed it in small bowls. DA J used gloved hands to scoop left over fruit from one pan to the other; -On 3/6/20 at 12:42 P.M., Cook K stood at the steam table, wore gloves and took plates from the shelf with fingers on the eating surface, filled the plate, placed gloved right hand on the steam table, palm down and repeated the process; -On [DATE] at 7:56 A.M., Cook K wore gloves, took a plate from the shelf with fingers on the eating surface, filled the plate, reached for another plate with fingers on the eating surface, served the plate, picked up a dispenser and poured eggs onto the grill, reached into a metal container, took a piece of cheese out and placed it on top of the eggs on the grill and continued to serve more plates of food. Cook K picked up a pancake, placed it on a cutting board, placed his/her gloved left hand on top of the pancake, cut it up with a knife and scooped up the pancake pieces and placed them on a plate. During an interview on [DATE] at 8:49 A.M., the chef said he expected staff to change gloves and wash hands between tasks. Gloved hands should not

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCKNIGHT PLACE EXTENDED CARE	TWO MCKNIGHT PLACE SAINT LOUIS, MO 63124

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

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) touch soiled surfaces such as the grill or steam table. Staff should use utensils to scoop fruit. They use a dry towel to polish utensils to remove water spots.
F 0849 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to collaborate with hospice in the development of a coordinated plan of care for residents receiving hospice care. The facility identified six residents on hospice care and three of those residents were selected for the sample of 14. Problems were found with two of them (Residents #16 and #36). The census was 56. 1. Review of Resident #16's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/25/19, showed the following: -No cognitive impairment; -Did not have a condition or chronic disease that might result in a life expectancy of less than 6 months; -Section O, special treatments and programs, hospice care not indicated; -[DIAGNOSES REDACTED]. Review of the resident's physician's orders [REDACTED]. Review of the resident's care plan, updated on [DATE], showed the following: -Focus, psychosocial well-being, resident has terminal [DIAGNOSES REDACTED]. Review of the hospice provider's binder, left at the nurses station, showed only handwritten documentation of the social worker and chaplain's visits to the resident. During an interview on [DATE] at approximately 11:00 A.M., LPN D stood at the Magnolia nurse's station and said he/she did not know if there was an additional hospice binder, looked on the shelf and said he/she could not find one. 2. Review of Resident #36's admission MDS, dated [DATE], showed the following: -Moderately impaired cognitive skills for daily decision making; -Total dependence on staff for transfers, toilet use, personal hygiene and bathing; -Had a condition or chronic disease that might result in a life expectancy of less than 6 months; -Received hospice care; -[DIAGNOSES REDACTED]. Review of the resident's POS, dated March 2020, showed an order, dated 12/20/19, to admit to hospice care. Review of the resident's care plan, updated on 1/27/20, showed the following: -Focus, psychosocial well-being, resident has terminal [DIAGNOSES REDACTED]. Review of the hospice binder kept at the nurses station, showed only handwritten documentation of the social worker and chaplain's visits to the resident. During an interview on [DATE] at 9:30 A.M., the Director of Nursing (DON) said the hospice provider comes in three times a week and their nurses are able to document in the progress note of the electronic medical record. The aides, social worker and chaplain, documented in the binder kept at the nurses station. Hospice plans of care were uploaded and scanned into the system under the miscellaneous tab, or could be found in the hospice binder. The facility's care plan did not show a delineation of duties between the facility and hospice provider because there were none. They still provided care to the residents as if they were not on hospice care. She expected the facility's care plan to say the resident was on hospice and refer to the hospice care plan.
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** Based on observation, interview and record review, facility staff failed to follow their policy and acceptable infection control practices to prevent the spread of infection by not [MEDICATION NAME] appropriate hand hygiene during resident contact for four residents (Residents #259, #15, #49 and #31) and failed to keep the supra pubic catheter (SP cath- small rubber tube inserted through the abdomen in to the bladder to drain urine) and indwelling urinary catheter (small rubber tube inserted in to the bladder to drain urine) tubing and drainage bag off of the floor for two residents (Residents #33 and #5). The sample size was 14. The census was 56. Review of the facility's Infection Control Guidelines for All Nursing Procedures Policy, dated 2005 and last revised April 2013, showed the following: -Purpose: To provide guidelines for general infection control while caring for residents: -General Guidelines: -1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes; -2. Transmission Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. -3. Employees must wash their hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: -a. Before and after direct contact with residents; -b. When hands are visibly dirty or soiled with blood or body fluids; -c. After contact with blood, body fluids, secretions, mucous membranes, or non-intact skin; -d. After removing gloves; -e. After handling items potentially contaminated with blood, body fluids, or secretions; -f. Before eating and after using a restroom; and -g. When there is likely exposure to spores, alcohol based hand rubs are ineffective and soap and water must be used; -4. In most situations, the preferred method of hand hygiene is with an alcohol based hand rub. If hands are not visibly soiled, use an alcohol based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for all the following situations: -a. Before and after direct contact with residents; -b. Before donning sterile gloves; -c. Before performing any non-surgical invasive procedures; -d. Before preparing or handling medications; -e. Before handling clean or soiled dressings, gauze pads, etc.; -f. Before moving from a contaminated body site to a clean body site during resident care; -g. After contact with resident's intact skin; -h. After handling used dressings, contaminated equipment, etc.; -i. After contact with objects (medical equipment) in the immediate vicinity of the resident -j. After removing gloves; -5. Wear personal protective equipment as necessary to prevent exposure to spills or splashed of blood or body fluids or other potentially infectious materials; -6. In addition to these general guidelines, refer to procedures for any specific infection control precautions that may be warranted. Review of the facility's Handwashing/Hand Hygiene Policy, dated 2001 and last revised August 2015, showed the following: -Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infection; -Policy Interpretation and Implementation: -1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare associated infections; -2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors; -3. Hand hygiene products and supplies (sinks, soap, towels, alcohol based hand rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies; -4. Triclosan (antibacterial/anti-fungal) containing soaps will not be used; -5. Residents, family members and/or visitors will be encouraged to practice hand hygiene through the use of fact sheets, pamphlets and/or written materials provided at the time of admission and/or posted throughout the facility; -6. Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations: -a. When hands are visibly soiled; -b. After contact with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and [MEDICAL CONDITION]; -7. Use an alcohol based hand rub containing at least 62% alcohol, or alternatively soap and water for the following situations: -a. Before and after coming on duty; -b. Before and after direct contact with residents; -c. Before preparing or handling medications; -d. Before performing any non-surgical invasive procedures; -e. Before and after handling an invasive device (e.g. urinary catheters, IV access sites); -f. Before donning sterile gloves; -g. Before handling clean or soiled dressings, gauze pads, etc.; -h. Before moving from a contaminated body site to a clean body site during resident care; -i. After contact with a resident's intact skin; -j. After contact with blood or bodily fluids; -k. After handling used dressings, contaminated equipment, etc.; -l. After contact with objects (medical equipment) in the immediate vicinity of the resident; -m. After removing gloves; -n. Before and after entering isolation precaution settings; -o. Before and after eating or handling food; -p. Before and after assisting a resident with meals; -q. After personal use of the toilet or conducting your personal hygiene; -8. Hand hygiene is the final step after removing and disposing of personal protective equipment; -9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections; -10. Single use disposable gloves should be used: -a. Before aseptic (clean of infectious organisms) procedures; -b. When anticipating contact with blood or body fluids; -c. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. 1. Review of Resident #259's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated [DATE], showed the following: -Severe cognitive impairment; -Required extensive assistance with personal hygiene; -Occasionally incontinent of bladder and frequently incontinent of bowel; -[DIAGNOSES REDACTED]. Observation on 3/4/20 at

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) 8:05 A.M., showed Certified Nurse's Aide (CNA) E entered the resident's room and donned gloves without washing his/her hands. He/she removed the covers from the bed, which exposed a saturated with urine brief. He/she lowered the brief and provided incontinence care. Patient Care Supervisor (PCS) F also present in the room and without washing hands or donning gloves, assisted to turn the resident to his/her left side which exposed a saturated with urine bed pad and bottom sheet. The back of the resident's shirt was also observed to be saturated with urine. CNA E cleansed the resident's buttocks and posterior thighs, PCS F donned gloves and both employees removed the linen from the bed, sat the resident at the side of the bed and removed his/her shirt. CNA E removed his/her gloves and transferred the resident to the shower chair and wheeled him/her to the shower. PCS F washed his/her hands. 2. Review of Resident #15's admission MDS, dated [DATE], showed the following: -Moderate cognitive impairment; -Unable to ambulate; -Extensive assistance required for all care; -Frequently incontinent of bowel; -[DIAGNOSES REDACTED]. Observation on 3/5/20 at 11:08 A.M., showed CNAs B and C entered the resident's room with a Hoyer lift (mechanical lift use to transfer a resident from one area to another), both washed hands, did not don gloves, lay the catheter bag on the resident's lap and transferred him/her to bed. CNA C lifted the catheter bag approximately three feet over the resident's body then lowered it and hung the bag on the bed frame. PCS F entered the room, did not wash hands or don gloves and all three staff turned him/her to his/her left side and lowered his/her slacks, which showed a dry dressing on his/her coccyx area. CNAs B and C pulled the resident's slacks back up while PCS F removed the resident's heel boots, which exposed a dressing to both heels. During an interview on 3/5/20 at approximately 11:15 A.M., PCS F said we were told by state that we should treat people as though they are in their home and we don't use gloves unless dealing with body fluids. 3. Review of Resident #49's admission MDS, dated [DATE], showed the following: -admitted to the facility on [DATE]; -Moderate cognitive impairment; -Extensive assistance required for mobility and personal care; -[DIAGNOSES REDACTED]. Observation on 3/6/20 at 8:04 A.M., showed Licensed Practical Nurse (LPN) D entered the resident's room and without washing his/her hands or donning gloves, assisted the resident to turn to his/her left side, pulled up his/her shirt and displayed the gauze dressing over the pleur X drain (flexible tube placed in the chest to drain fluid from the pleural space (sac surrounding the lung)). During an interview on 3/6/20, at approximately 8:10 A.M., LPN D said typically he/she would wash his/her hands when entering and when leaving a room but did not do it now because I knew I wasn't going to touch anything. When asked if it would be best to at least wash hands before touching a resident's bare skin, the LPN said I knew the dressing was dry and I wasn't going to get in to any drainage. During an interview on [DATE] at 1:30 P.M., the Director of Nursing (DON) said staff should always wash their hands when entering and when leaving a resident's room. It was okay to dress someone without wearing gloves, but if there is a chance of contact with body fluids, the staff member should wear gloves. It is never permissible to touch urine or any other body fluid without wearing gloves, and when checking a dressing, staff should wash their hands and don gloves. 4. Observation on 3/6/20 at 8:35 A.M., showed CNA G got Resident #31 dressed and took him/her down the hall to get weighed. PCS F and CNA I, without washing their hands or applying gloves, stood the resident up, using a gait belt, which caused the resident's shirt to rise up, with staff touching his/her bare back and then asked him/her to step off to reset the scale. Then they held onto the gait belt, asked him/her to step back onto the scale and weighed him/her. They then transferred him/her back into the wheelchair and adjusted his/her feet on the foot rests of the wheelchair, touching the bottom of his/her shoes. Then PCS F rolled the scale back to the closet down the hall, without washing his/her hands. At no point did either staff member wash their hands or apply gloves. 5. Review of Resident #33's significant change MDS, dated [DATE], showed the following: -Moderately impaired cognitive skills; -Limited assistance of staff for most activities of daily living (ADLs); -Indwelling catheter; -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated 10/23/19, showed the following: -Focus, has Foley (type) catheter, 16 French (size), 10 cubic centimeter (cc) balloon related to enlarged prostate; -Goal, will remain free from catheter-related trauma through review; -Interventions, position catheter bag and tubing below the level of the bladder and away from entrance room door, check tubing for kinks each shift, monitor and document intake and output as per facility policy, monitor/document for pain/discomfort due to catheter, monitor/record/report to MD for signs and symptoms of urinary tract infection [MEDICAL CONDITION], pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating. Review of the resident's physician's orders [REDACTED]. Document output and provide catheter care every shift. Review of the resident's progress notes, showed long term antibiotic use for urinary tract infection [MEDICAL CONDITION], as far back as May 2019. Review of the resident's POS, dated January and February 2020, showed the following: -An order, dated 1/5/20 for [MEDICATION NAME] (antibiotic) 250 milligrams (mg) by mouth two times a day for UTI for seven days; -An order, dated [DATE], for [MEDICATION NAME] 250 mg by mouth two times a day for UTI for five days. Review of the resident's medication administration records, dated January and February 2020, showed the following: -[MEDICATION NAME] 250 mg by mouth two times a day for UTI for seven days, given as ordered; -[MEDICATION NAME] 250 mg by mouth two times a day for UTI for five days, given as ordered. Observation of the resident showed, the following: -On 3/5/20 at 1:22 P.M., the resident sat in a wheelchair at the dining room table and a urine drainage bag inside a privacy bag sat on top of the catheter tubing, which lay on the floor underneath the wheelchair. -On 3/6/20 at 12:23 P.M., a staff member pushed the resident down the hall in a wheelchair, with the catheter tubing dragging on the floor; -On 3/6/20 at 12:26 P.M. and 1:00 P.M., the resident sat in a wheelchair at the dining room table and catheter tubing lay on the floor underneath the wheelchair. 6. Review of Resident #5's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Extensive assistance of staff required for activities of daily living; -Incontinent of bowel and bladder; -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated on [DATE]5/19, showed the following: -Focus, functional bladder incontinence related to [MEDICAL CONDITION], confusion and impaired mobility; -Goals, risk for [MEDICAL CONDITION] (blood infection) will be minimized/prevented via prompt recognition and treatment of [REDACTED]. Review of the resident's POS, dated March 2020, showed an order, dated 2/19/20 for indwelling catheter, 16 French with 30 cc balloon, to help promote sacral wound healing, change monthly and as needed. Observation of the resident on 3/6/20 at 12:28 P.M., showed the resident sat in a wheelchair at the dining room table, a urinary collection bag contained in a privacy bag attached to the bottom of the wheelchair, and the catheter tubing lay on the floor underneath the wheelchair. During an interview on [DATE] at 9:30 A.M., the DON said catheter tubing should never be on the floor related to infection control concerns. Review of the facility's urinary catheter care policy, revised 1/1/2020, showed the following: -Purpose: The purpose of this procedure is to prevent catheter-associated urinary tract infections; -Infection control: Be sure the catheter tubing and drainage bag are kept off the floor.