STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265581	A. BUILDING _____ B. WING _____	05/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FULTON PRESBYTERIAN MANOR	811 CENTER STREET FULTON, MO 65251

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** - Many	**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 maintain an ongoing effective Infection Control system for identifying, monitoring, tracking and trending infections. The facility failed to ensure staff wore their cloth face masks appropriately for COVID-19 per Centers for Disease Control and Prevention (CDC) guidelines. The facility identified a census of 25 residents. Findings include: 1. Review of the facility Infection Control Log consisted of a Procedure Log. The log included a daily tracking of any residents with falls, weight monitoring, vital sign monitoring etcetera (etc.) and was not specific to infections. On 5/13/20 at 2:02pm Licensed Practical Nurse (LPN1) indicated she monitored infections in the facility and utilized the Procedure Log to track infections. When asked how she identified trends, LPN1 indicated she reviewed the Procedure Log to identify residents on antibiotics and accessed the computer. LPN1 indicated that when a resident received an antibiotic, it was included in the computer on the Infection Report. The Infection Report consisted of the type of infection, results of tests, organisms and linked medications and notes taken for the infection. LPN1 indicated the Director of Nursing (DON) reviewed the information via a computerized report. LPN1 indicated the DON provided education to staff if trends were identified. R1's electronic medical record (eMR) interdisciplinary (ID) note recorded on 12/29/19 at 9:15pm that R1 had not urinated the whole day. Staff catheterized R1 to obtain a urine sample for a urinalysis (UA). Four days later on 1/2/20 at 1:10pm the ID note recorded an order for [REDACTED]. On 1/3/20 the Infection Report identified R1 received Bactrim (an antibiotic) for a UTI. The report did not include any information related to the date the UA was obtained, symptoms displayed, results of the culture or that the resident was [MEDICATION NAME] to the results of the culture. On 1/4/20 the Procedure Log recorded R1 with a UTI. The Log lacked any further information related to R1's UTI. Review of the January 2020 Infection Control map identified R1 had a UTI but did not specify if it was catheter associated or not and did not identify the organism [MEDICAL CONDITION]. R2's eMR revealed on 12/31/19 a urinalysis was completed and based on the results required a culture. On 1/1/20 the culture tested negative for bacteriuria infection. There was not an Infection Report completed for the resident to indicate the urinalysis or culture were completed. Review of the computerized report did not include R2 and was not included on the January 2020 Infection map. R2's 2/7/20 at 1:10pm ID note recorded R2's Influenza A & B test was negative. The Influenza test was not recorded on the February 2020 Infection map, on an Infection Report, or on the computerized report. R7's 1/6/20 Infection Report recorded R7 had an indwelling Foley catheter related UTI and the cultured organism was [DIAGNOSES REDACTED] Aureus (a type of bacterial infection). Under the title Comments recorded R7 had a cystoscopy (an instrument inserted into the urethra to examine the urinary bladder) and stent placement (a procedure to insert a drainage tube into the kidney due to a blocked ureter (the tube that brings the urine from the kidney to the bladder) and on 1/11/20 R7 admitted to the hospital with [REDACTED]. The January 2020 Infection map recorded R7 had a UTI. The map did not indicate if the UTI infection was catheter associated or not nor the organism involved. The computerized report recorded R7 had a UTI and the organism was [DIAGNOSES REDACTED] Aureus but did not include that is was [MEDICAL CONDITION]-resistant. R16's 2/4/20 Infection Report recorded the resident with a UTI, not catheter associated, did not have a culture with Organism listed as other. Under the title Medication [MEDICATION NAME] mg. Record review of the 2/4/20 urinalysis test recorded a urine culture was indicated. The 2/6/20 BacteriScan (a type of lab test to detect bacteria in the urine) Urinary Tract Infection Detection report recorded the results as presumptive positive of bacteriuria. The test was related to Microorganism identification. R16's eMR did not indicate the organism involved. The 2/14/20 at 2:42pm ID note recorded an order for [REDACTED]. The computerized report recorded R16 had a UTI and the organism was listed as other. No further information was available to indicate the type of organism R16 had. R6's 2/13/20 at 1:59pm ID note recorded UA results were sent to the physician via facsimile (fax) and waiting for the culture and sensitivity (C&S) results. The 2/15/20 at 9:55pm ID note recorded the facility received a call from the lab with the results of the UA and the resident was positive for Extended Spectrum Beta Lactamase (ESBL-chemicals produced from certain types of bacteria in the urine). The 2/17/20 at 9:55pm ID note recorded the physician stated to do another urine culture. On 2/25/20 at 6:50am the ID note recorded the physician received the urine C&S report with an order not to treat at this time. On 3/31/20 at 11:10am, the ID note recorded staff obtained a UA from R6's indwelling Foley catheter. An Infection Report was not provided for review, was not included on the February 2020 map, and was not included on the computerized report. On 4/4/20 at 8:08pm the ID note recorded R6 had an ongoing cough with white frothy sputum and course lung sounds. R6 was sent to the emergency department (ED). The 4/4/20 at 6:39pm ID note recorded the facility received a call from the lab and R6's urine culture was positive for EBSL. The eMR recorded the resident was admitted to the hospital for urosepsis (a type [MEDICAL CONDITION] limited to the urinary tract). An Infection Report was not available for review. The March and April Infection maps did not include R6 and the computerized report did not include R6. R8's 2/27/20 Infection Report recorded the resident had pneumonia, his fever increased to 105.1 degrees () Fahrenheit (F) later in the evening and was transferred to the hospital. The February 2020 Infection map did not include R8. R8's 3/1/20 at 7:36pm ID note recorded the resident returned to the facility from the hospital after being treated for [REDACTED]. The 3/2/20 urine culture recorded the resident with a UTI and the organism was Escherichia coli (E-coli - a type of bacteria that normally live in the intestines). An Infection Report was not available for review. The February and March 2020 Infection maps did not include R5. R15's 3/16/20 Infection Report recorded other for the type of infection. The comments section recorded the resident was short of breath, had a productive cough, did not have a fever, and was prescribed [MEDICATION NAME] (an antibiotic in generic form). After two weeks similar symptoms started again and was prescribed [MEDICATION NAME]. R15 was not included on the March 2020 Infection map. R5 was listed on the computerized report as other. During an interview on 5/13/20 at 3:59pm, the DON indicated the facility utilized the Infection Report to record infections and track them through the computer system and the infections were mapped each month and included on the Procedure Log for monitoring. The DON indicated that when a resident was prescribed an antibiotic, an Infection Report was generated by staff in the computer that included the test, organism, and included comments describing any further details of the infection. The DON indicated he was able to pull a computerized report from the information collected to track and trend infections. During an interview on 5/18/20 at 8:55am, the DON indicated any residents with infections should be identified on the map, on an Infection Report and included on the computerized report. 2. Observations on 5/13/20 at the following times revealed: - 12:46pm, Housekeeper (H1) came out of a resident room with her cloth face mask down below her nose. Nurse Aide (NA1) wore a cloth face mask with her nose exposed while pushing a resident in a wheelchair in the hallway. Three dietary staff were in a separate but attached dining area were residents were sitting. Two of the dining staff allowed both their nose and mouth to be exposed and were not [MEDICATION NAME] social distancing. - 1:08pm NA1 sat at a table in the dining room with R3 and R11. NA1's cloth face mask was below her nose. Dietary staff (D1) was in the same dining room with her cloth face mask down around her neck exposing her nose and mouth. - 1:53pm NA1's cloth mask was down exposing her nose while residents were present. - 2:02pm NA1's cloth mask was down exposing her nose while residents were present. - 4:54pm NA2's cloth mask was off while she ate food at the nurses' station

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) area. Social distancing was not being practiced as other staff were standing less than 6 feet from NA4. Residents were in the hall near the nurses' station area. - 5:05pm D2 wore a face mask that exposed her nose. D2 entered R13 and R14's room to serve their supper meal. D2 came out of the room and continued down the hall serving residents their meals in their rooms. -5:14pm NA3 sat next to R1 at the dining room table with her face mask on exposing her nose. During an interview on 5/13/20 at 5:05pm, the Administrator indicated staff were to wear their cloth masks at all times while in the building with the exception of removing it to take a drink but eating was not allowed on the units. The Administrator indicated both the nose and mouth should be covered at all times and if the mask did not fit well to allow this, then staff should select a mask that did fit well.