| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **265140** | A. BUILDING _____ B. WING _____ | **07/29/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **MARYMOUNT MANOR** | **313 AUGUSTINE RD, PO BOX 600 EUREKA, MO 63025** |

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) |
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| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to protect four residents (Residents #1, #2, #3 and #4) from potential harm by not following the facility policy for transferring with a Hoyer lift (mechanical lift used to transfer a resident from one surface to another) for four of four Hoyer lift transfers observed. The sample size was nine. The facility census was 73. Review of the facility's Hoyer Lift Policy, revised on 7/27/20, showed the following: Any resident who cannot stand and bear weight is to be transferred with a mechanical lift device, such as a Hoyer lift. The Hoyer lift transfers require two staff members with the transfer; -Knock on the resident's door, introduce yourself, wash hands, apply gloves, and then explain procedure to resident before transferring the resident with the Hoyer lift. Please make sure the residents' door is closed for privacy; -All Hoyer lifts must be sanitized prior to use per nursing staff and after use per nursing staff. (Sanitize with bleach wipes or other disinfectant); -One staff member is the controller of the Hoyer lift and the other staff member is the spotter while the Hoyer lift is in use for transfers; -Wheel the Hoyer lift into place over the resident with the base beneath the bed/chair/wheelchair. Hoyer stand should be open in width for stability; -Attach the sling to the mechanical lift with the correct Hoyer pad hooks in place; -Have the resident fold both arms across their chest, if possible; -Lift the resident until the buttocks are clear of the bed/chair/wheelchair. Make sure the resident is aligned in the sling and is securely suspended in a position with legs dangling over the bottom of the sling. The controller/spotter will continue to have hands continually on the resident alternating as needed while the resident is being transferred in the Hoyer lift to bed/chair/wheelchair. Hoyer stand should be open in width for stability; -Nursing staff will communicate to the resident while using the Hoyer lift; -Nursing staff will then place the resident over bed/chair/wheelchair and lower the resident into position utilizing the controller slowly into place, monitoring the resident's legs for proper placement. Nursing staff to monitor proper positioning of the resident in chair and wheelchair. Hoyer stand should be in open width for stability. Nursing staff continues to have a spotter with hands continually on the resident while Hoyer lift transfer is in use; -Remove the Hoyer pad hooks from the lift. Place call light and all personal items in resident's reach; -Remove gloves and wash hands prior to exiting the room. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/3/20, showed the following: -No cognitive impairment; -Unable to ambulate; -Dependent on staff for transfers, dressing and toileting; -[DIAGNOSES REDACTED]. Review of the current physician's orders [REDACTED]. Review of the care plan, updated 3/10/20, showed the following: -Problem: Fall risk due to limited mobility; -Goal: Utilize approaches to help prevent falls and/or injury; -Interventions: Call light in reach at all times and prompt response to request, right and left grab bars for assistance with bed mobility, Hoyer lift transfer with two staff support-ensure sling pad and lift are in good repair prior to any use, keep bed in lowest position, fall mats to both sides of the bed. Observation on 7/27/20 at 6:32 A.M., showed the resident lay in bed on a Hoyer sling (large piece of material used to cradle the resident during transfer). Certified Nurse Aides (CNA) A and B entered the room with a Hoyer lift. CNA B rolled the lift under the bed with the legs closed and CNA A walked to the opposite side of the bed. Both CNAs connected the sling to the lift, CNA B raised the resident approximately 1 foot over the bed and backed the lift away from the bed. With the resident hanging approximately 4 feet above the floor and the lift legs in the closed position, CNA B pulled the lift backwards 6 feet into the hallway. CNA A, approximately 8 to 10 feet away, rolled the wheelchair to the lift as CNA B opened the legs of the lift. CNAs A and B lowered the resident into the wheelchair. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unable to ambulate; -Dependent on staff for transfers, mobility, dressing, toileting and personal hygiene; -[DIAGNOSES REDACTED]. Review of the current POS, showed no order for Hoyer transfer. Review of the care plan, last updated 7/24/20, showed Hoyer transfer not addressed. Observation on 7/27/20 at 6:41 A.M., showed the resident lay in bed on a Hoyer sling. CNA B rolled the Hoyer lift under the bed with the legs closed and CNA A walked to the opposite side of the bed. Both CNAs connected the sling to the lift, CNA B raised the resident approximately 1 foot over the bed and backed the lift away from the bed. With the resident hanging approximately 4 feet above the floor and the lift legs closed, CNA B pulled the lift backwards approximately 6 feet into the hallway. CNA A, approximately 8 to 10 feet away, rolled the wheelchair to the lift as CNA B opened the legs of the lift. CNAs A and B lowered the resident into the wheelchair. 3. Review of Resident #3's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unable to ambulate; -Dependent on staff for bed mobility, locomotion, dressing, toileting and hygiene; -[DIAGNOSES REDACTED]. Review of the current POS, showed an order, dated 1/15/19, for Hoyer lift transfers. Review of the care plan, dated 3/5/20, showed the following: -Problem: Fall risk related to immobility and lack of safety awareness at times. Resident at times tries to get out of bed without staff assistance. Provide frequent rounds for proper positioning while in bed. Resident also has a [MEDICAL CONDITION] disorder; -Goal: No goals provided; -Interventions: Bed in lowest position with fall mats on both sides of the bed, bolster mattress, wheelchair with foot board, frequent rounds for cares, reposition for safety and comfort in bed and wheelchair and transfer with a Hoyer lift with two staff assist ensuring sling pad and machine are in good repair prior to any use. Observation on 7/27/20 at 6:57 A.M., showed the resident lay in bed on a Hoyer sling. CNA B rolled the Hoyer lift under the bed with the legs closed and CNA A walked to the opposite side of the bed. Both CNAs connected the sling to the lift and CNA B raised the resident approximately 1 foot over the bed and backed the lift away from the bed. With the resident hanging approximately 4 feet above the floor and the lift legs closed, CNA B pulled the lift backwards approximately 6 feet into the hallway. CNA A, approximately 8 to 10 feet away, rolled the wheelchair to the lift as CNA B opened the legs of the lift. CNAs A and B lowered the resident into the wheelchair. 4. Review of Resident #4's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unable to ambulate; -Dependent on staff for bed mobility, transfers, toileting and personal hygiene; -[DIAGNOSES REDACTED]. Review of the current POS, showed an order, dated 1/15/19, to utilize a Hoyer lift for transfers. Review of the care plan, dated 12/16/19, and last updated on 1/16/20, showed the following: -Problem: Resident is dependent upon staff for transfers due to lower extremity contractures and cognitive decline. He/she is at risk for falls and related injuries; -Goal: No fall events with use of interventions; -Interventions: Keep bed in low position with falls mats on both sides of the bed, ensure glasses are clean and worn daily, frequent rounds for personal care as needed, frequent rounds while resident is in bed for positioning, Hoyer lift transfers with two staff assist, ensure sling and machine are in good working condition, intervene as needed due to resident's lack of safety awareness, manual wheelchair and restorative therapy two times a week. Observation on 7/27/20 at 7:05 A.M., showed the resident lay in bed on a Hoyer sling. CNA B rolled the Hoyer lift with the legs closed under the bed and CNA A walked to the opposite side of the bed. Both CNAs connected the sling to the Hoyer and CNA B raised the resident approximately 1 foot over the bed and pulled the lift back approximately 4 feet, which left the |

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 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>resident hanging approximately 4 feet above the floor. CNA A stepped into the hallway to retrieve the wheelchair and returned to the room At that time, CNA B opened the legs of the Hoyer, CNA A rolled the wheelchair into the legs of the Hoyer and they lowered the resident into the wheelchair. 5. During an interview on 7/27/20 at approximately 7:13 A.M., CNAs A and B said the legs of the Hoyer should be closed at all times and only opened to allow the wheelchair to fit into the legs of the lift. CNA A said they have to pull the Hoyer into the hallway to complete the transfers because there just was not enough space in the rooms to complete the transfer. 6. During an interview on 7/27/20 at 9:35 A.M., the Director of Nursing said any resident that is transferred with a Hoyer lift should have a physician's orders [REDACTED]. She said Resident #1 is and has been transferred with a Hoyer lift, and the order on the POS needed to be changed. The legs of the Hoyer lift should be open at all times during the transfer to provide stability, and the second person, the spotter, should have hands on the resident throughout the transfer. The spotter should never be across the room. She said there was never a reason to extend the transfer into the hallway and there is enough room in the resident rooms to complete the transfers. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to properly contain COVID-19 by not following facility policies and current standards of practice regarding the control of infection transmission. The facility failed to ensure hand hygiene was performed appropriately and failed to ensure a Hoyer (mechanical) lift was disinfected before/after use for (Residents #1, #2, #3 and #4). In addition, the facility failed to ensure residents who were out of their rooms wore/encouraged face masks, failed to ensure/encourage social distancing was maintained for residents during meal service and while in common use areas, and failed to ensure one resident (Resident #2) was quarantined for 14 days after being discharged from the hospital. The resident sample size was nine. The census was 73. Review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID 19 in Nursing Homes guidelines, updated 6/25/20, showed the following: -Residents should wear a cloth face mask covering or facemask (if tolerated) whenever they leave their room; -Implement aggressive social distancing measures (remaining at least 6 feet apart from others): -Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene. -Considerations when restrictions are being relaxed include: -Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate. -Healthcare Providers (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing personal protective equipment (PPE), including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process; -HCP should perform hand hygiene by using alcohol based hand sanitizer (ABHS) with 60-95 percent alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS; -Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown: Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Review of the facility's undated COVID-19 Prevention Policy, showed the following: -In conjunction with Department of Health and Senior Services (DHSS), Center for Medicare Services (CMS), CDC, medical director and interdisciplinary team, the following measures should be implemented; -Resident monitoring and restrictions: All residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If the residents leave their room, residents should wear a facemask, perform hand hygiene, limit their movements in the facility and perform social distancing (stay at least 6 feet away from others).<br>Review of the facility's revised Handwashing Policy, dated 4/2/19, showed the following: -Handwashing remains the single most effective means of preventing disease transmission. Wash hands often, paying particular attention to around and under fingernails and between fingers; -Wash hands whenever they are soiled with body substances, before performing invasive procedures and when each resident's care is completed. Review of the facility's Hoyer Lift Policy, revised on 7/27/20, included the following: -Knock on the resident's door, introduce yourself, wash hands, apply gloves, and then explain procedure to resident before transferring the resident with the Hoyer lift. -All Hoyer lifts must be sanitized prior to use per nursing staff and after use per nursing staff. (Sanitize with bleach wipes or other disinfectant). Review of the COVID-19 Facility Survey report submitted by the facility, dated 7/23/20, showed the facility had a recent resident who tested positive for COVID-19 on 7/22/20. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/3/20, showed the following: -No cognitive impairment; -Unable to ambulate; -Dependent on staff for transfers, dressing and toileting; -[DIAGNOSES REDACTED]. Observation on 7/27/20 at 6:32 A.M., showed the resident lay in bed on a Hoyer sling (large piece of material used to cradle a resident during transfer). With bare, unwashed hands, Certified Nurse Aide (CNA) A rolled the Hoyer lift to the doorway, entered the room, removed the top covers and raised the bed to hip level. CNA B rolled the Hoyer into the room and both CNAs, without washing their hands or donning (putting on) gloves, connected the Hoyer sling to the Hoyer lift and transferred the resident to the wheelchair. CNA B wheeled the Hoyer lift into the hallway and then wheeled the resident in the wheelchair, down to the common room. CNA B did not offer the resident a mask. CNA A stripped the top covers from the bed, placed them in a plastic bag and discarded the bag in the soiled utility room. Still without washing his/her hands, CNA A entered the linen closet, retrieved a sheet and blanket and returned to the resident's room and made his/her bed. Neither CNA washed their hands. Review of Resident #2's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unable to ambulate; -Dependent on staff for transfers, mobility, dressing, toileting and personal hygiene; -[DIAGNOSES REDACTED]. Observation on 7/27/20 at 6:41 A.M., showed the resident lay in bed on a Hoyer sling. CNA B entered the resident's room, did not wash hands or don gloves, raised the head of the bed, removed the cup from the bedside table and assisted the resident with a drink of water. Without washing his/her hands or donning gloves, CNA A entered the room, lowered the head of the bed, raised the bed to hip level, and removed the top covers. CNA B retrieved the Hoyer lift from the hallway, did not clean the Hoyer lift and both CNAs connected the Hoyer sling to the Hoyer lift and transferred the resident to the wheelchair. After disconnecting the sling from the lift, CNA B rolled the lift into the hallway and did not clean the lift. CNA A made the bed while CNA B wheeled the resident to the common room where two other residents, without masks, were already seated. CNA B did not offer Resident #2 or the other two residents a mask. Neither CNA washed their hands. Review of Resident #3's annual MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unable to ambulate; -Dependent on staff for bed mobility, locomotion, dressing, toileting and hygiene; -[DIAGNOSES REDACTED]. Observation on 7/27/20 at 6:52 A.M., showed the resident lay in bed on a Hoyer sling. Without washing their hands or donning gloves, CNAs A and B entered the resident's room. While CNA A raised the bed and removed the covers, CNA B positioned the Hoyer lift around the bed. Both CNAs connected the sling to the lift and transferred the resident to a wheelchair. After releasing the sling from the lift, CNA B rolled the lift to the hallway without cleansing the lift. Without washing his/her hands, CNA B rolled an over-bed table to a resident who sat in the hallway and assisted him/her with a drink of water. CNA A combed Resident #3's hair and rolled him/her to the common room. Neither CNA offered the resident a mask. CNA A then entered the linen room, removed a sheet and blanket from the cart, returned to the resident's room and made the bed. CNA A did not wash his/her hands. Review of Resident #4's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Unable to ambulate; -Dependent on staff for bed mobility, transfers, toileting and personal hygiene; -[DIAGNOSES REDACTED]. Observation on 7/27/20 at 7:05 A.M., showed the resident lay in bed on a Hoyer sling. CNA B entered the room with the Hoyer lift. Without washing hands or donning gloves, CNA A removed the bed covers and both CNAs connected the sling to the lift. After transferring the resident to the wheelchair, CNA B rolled the Hoyer into the hallway. He/she did not cleanse the lift and neither CNA washed their hands. During an interview on 7/27/20 at approximately 7:13 A.M., both CNAs A and B said the Hoyer lift should be sanitized every weekend, and their hands should be cleansed between changing residents and when documenting care. When the CNAs were asked why they did not wash their hands at all during the four transfers, CNA A said they really should have sanitized their hands between each resident. During an interview on 7/27/20 at 9:35 A.M., the Administrator and Director of Nursing (DON) said all reusable medical equipment, including the Hoyer lift, should be sanitized before and after each use. Staff were aware that bleach wipes were kept at the nurses' desk, in the medication carts, in the clean utility room, and in the shower rooms. Reusable equipment should be |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 2)<br>sanitized before and after each use to prevent the spread of infection. They added that staff should wash their hands before and after each resident contact/transfers, and they should always wear gloves during resident care. 2. Review of Resident #2's nurses' notes, showed the following: -On 7/15/20, resident sent to the hospital via emergency medical services (EMS); -On 7/24/20, resident returned to the facility via EMS. He/she had surgery during hospitalization . Observation on 7/27/20 at 6:41 A.M., showed Resident #2 resided in the room with another resident with the beds approximately 8 feet apart. During an interview on 7/29/20 at 10:40 A.M., the DON verified Resident #2 returned to the facility from the hospital on [DATE]. She said the resident should have been quarantined in a private room for 14 days and should not be allowed to be around other residents. The DON said the resident's COVID-19 test was negative prior to being discharged back to the facility. The DON verified the facility does not have a specific quarantine policy and procedure. The DON said the facility did have an Infection Preventionist (IP), but that person had resigned. She and the Assistant Director of Nurses (ADONs) are currently taking the IP course to be certified as the facility's IP. 3. Observations of the 300 unit on 7/27/20, showed the following: -At 6:24 A.M., eight residents sat across from the nurses' desk. No resident wore a mask, and no staff member offered the residents a mask; -At 6:30 A.M. until 6:45 A.M., a total of seven residents sat approximately 18 to 24 inches apart from each other without facemasks. Nurse C and CNA D stood at the nurses' station, did not move the residents at least 6 feet apart for social distancing and did not offer and/or attempt to place facemasks on the residents. -At 7:48 A.M., eight unmasked residents remained seated across from the nurses' desk. All residents sat within 18 to 24 inches apart. One resident had a productive cough and spit [MEDICATION NAME] into a tissue. -At 8:14 A.M. until 8:45 A.M., a total of nine residents sat approximately 18 to 24 inches apart in front of the nurses' station during meal service. A total of five staff members present in front of the nurse's station, did not move the residents at least 6 feet apart for social distancing purposes. 4. Observation on 7/27/20 at 7:10 A.M. until 7:30 A.M., of the 200 unit, showed a total of five residents sat approximately 18 to 24 inches apart from each other in the television room without facemasks. CNA E and Nurse F stood in the television room, did not move the five residents at least 6 feet apart for social distancing and did not offer and/or attempt to place facemasks on the residents. 5. During an interview on 7/27/20 at 9:35 A.M., the Administrator and DON said they expected nursing staff to offer and/or attempt to place facemasks on residents when they are out of their rooms and expected staff to move residents at least 6 feet apart to maintain appropriate social distancing to prevent the spread of COVID-19. The resident who was coughing should have been taken to their room. |