STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265174	A. BUILDING _____ B. WING _____	09/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHRISTIAN EXTENDED CARE & REHABILITATION	**11160 VILLAGE NORTH DRIVE SAINT LOUIS, MO 63136**

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 0623 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to issue written emergency transfer/discharge notices to residents and/or residents' representatives when the residents were transferred to a hospital for various medical reasons, and failed to send a copy of the notice to a representative of the State Long-Term Care (LTC) Ombudsman, for three residents (Residents #7, #60, and #58). The sample was 12. The census was 45. 1. Review of Resident #7's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, admission and discharge assessments, showed: -admission date of [DATE]; -discharged to the hospital 4/25/20; -Readmission to the facility 6/2/20. Review of the resident's medical record, showed no documentation the resident and/or their representative were provided a written notice of the resident's transfer to the hospital. 2. Review of Resident #60's MDS admission and discharge assessments, showed: -admission date of [DATE]; -discharged to the hospital 8/25/20; -Readmission to the facility 8/28/20. Review of the resident's medical record, showed no documentation the resident and/or their representative were provided a written notice of the resident's transfer to the hospital. 3. Review of Resident #58's medical record, showed: -admission date of [DATE]; -discharged to the hospital 9/6/20; -Readmission to the facility 9/7/20; -No documentation the resident and/or their representative were provided a written notice of the resident's transfer to the hospital. 4. During an interview on 9/21/20 at 9:47 A.M., Nurse A said when a resident goes out to the hospital for a medical issue, the nurse is responsible for sending the red folder with the resident. The red folder has a checklist of documentation to send for the resident's transfer, such as physician orders, code status, and history and physical. To his/her knowledge, the red folder does not include a written notice regarding the resident's right to appeal the transfer or discharge. 5. Review of the facility's Acute Care transfer Checklist, revised 8/30/13, showed: -No statement of the resident's appeal rights, including the name, address, and telephone number of the entity which receives such requests; -No information on how to obtain an appeal form and assistance in completing the form and submitting the hearing request; -No name, address, and telephone number of the state LTC Ombudsman. 6. During an interview on 9/22/20 at 10:09 A.M., the administrator said residents are provided with a packet upon admission which includes the facility's bed hold policy and contact information for the Ombudsman and local state survey agency. When a resident goes out to the hospital, the nurse sends a red transfer checklist folder with the resident. The red folder does not contain a written notice of transfer/discharge including a statement of the resident's right to appeal, or the contact information for the Ombudsman and local state survey agency since this information was provided to the resident upon admission. To his/her knowledge, the facility was not sending a copy of transfer/discharge notices to the Ombudsman. 7. During an interview on 9/22/20 at 1:10 P.M., the administrator confirmed she could not locate documentation to show Residents #7, #60, and #58 and/or their representatives were provided with written notice of transfer/discharge, including the resident's rights to appeal. The facility is expected to follow the regulatory requirements for providing written notices of transfer/discharge.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 one of one resident sampled with a hand brace received assistance to wear the left hand brace per skilled therapy instructions (Resident #5). The total sample was 12. The census was 45. Review of Resident #5's significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 5/25/20, showed: -admission date of [DATE]; -[DIAGNOSES REDACTED]. Allow resident to wear as tolerated. He/she may remove the splint or ask staff to remove the splint; -Notify therapy of any redness or skin breakdown if it occurs. Review of the resident's quarterly MDS, dated [DATE], showed: -Makes self understood: Usually understood; -Ability to understand others: Sometimes understood; -Does not reject care; -Extensive assistance of one required for dressing; -Functional limitations in range of motion: Impairment of one upper extremity (shoulder, elbow, wrist or hand); -Occupation Therapy end date: 7/1/20. Observations on the following dates and times, showed: -9/16/20 at 10:40 A.M., the resident sat in a wheelchair in his/her room. His/her left had appeared contracted. He/she had no splint on; -9/17/20 at 10:27 A.M., the resident sat in a wheelchair in his/her room without a left hand splint on; -9/18/20 at 10:54 A.M., the resident sat in a wheelchair in his/her room without a left hand splint on. Observation on 9/22/20 at 8:33 A.M., after breakfast, showed the resident sat in his/her room in a wheelchair without a left hand splint on. Certified Nursing Assistant (CNA) H, assigned to care for the resident, said he/she had taken care of the resident several times before today. The CNA said the resident will usually not leave the hand splint on. The CNA found the hand splint in a drawer in the resident's room and placed it on upside down on the resident's right hand. He/she had just secured the last Velcro strap on the splint when CNA I came to the door. CNA I told CNA H the splint was on upside down. CNA H unstrapped the splint, turned it around and placed it back on the right hand and left the room. At 8:40 A.M., the surveyor asked the CNA to check the splint order on the restorative care program sheet. The CNA then checked the care tracker (electronic system CNAs access that shows what type of care a resident requires). The same order from the restorative care program sheet was in the the care tracker system. The CNA said he/she had not noticed it before and he/she did not know the splint was for the left hand, but is finding out now. The CNA went to the resident and moved the splint from the resident's right hand to the left hand. During an interview on 9/22/20 at 8:58 A.M., the therapy program director said the splint is to address the resident's contracture. The resident does take the splint off at times, but will usually wear it 40 to 60 minutes before he/she removes it, which is why she wrote the order for after meals. If the resident wears it about an hour each time then that's about three hours a day which would still be beneficial. She did not know why CNA H did not know how to apply the splint or which hand to wear it on because she recalls in-servicing CNA H about the splint. Observation on 9/22/20 at 11:10 A.M., showed the resident sat in the dining room with the left hand splint on. The resident did appear as if he/she was attempting to remove it at that time. During an interview on 9/22/20 at 1:00 P.M., the Director of Nurses said she expects staff to follow skilled therapy instructions for splints. If a resident refuses their splint, it should be documented.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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**

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

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Based on observation, interview and record review, the facility failed to have systems in place to ensure one resident received proper care and staff assistance while turning and positioning during incontinence care. The resident rolled from the bed, landed on the floor and sustained a left arm fracture (Resident #182). The sample was 12. The census was 45. Review of Resident #182's admission face sheet, showed an admission date of [DATE]. Review of a document titled CORP-One-Click (MDS 3.0, (Minimum Data Set, a federally mandated assessment instrument completed by facility staff)) Report (a seven day look back assessment completed by direct care staff showing the level of care a resident required during the assessment period and used by the facility MDS Coordinator to complete the residents MDS assessment. The assessment period for this report was 9/2/20 through 9/8/20. The report showed 17 entries, each entry represented a different date and shift. For bed mobility, the resident required: No setup or physical help from staff one time, set-up help only one time, one person physical assistance 13 times and two (+) person physical assistance two times. Review of the resident's admission MDS, dated [DATE], showed: -Makes self understood: Understood; -Understands others: Understands; -Brief Interview for Mental Status score of 03 out of 15 (a score of 00-07 indicates severe impairment); -Extensive assistance of two (+) persons required for bed mobility and transfers; -One person physical assistance required for bathing; -Impairment of one upper extremity; -Mobility device: Wheelchair; -[DIAGNOSES REDACTED].-Weight of 238 pounds. During an interview on 9/22/20 at 12:06 P.M., the MDS Coordinator said the seven day look back assessment is completed by the certified nursing assistants (CNA)s. She is required to code the level of assistance on the MDS based on the highest amount of assistance the resident received during that look back period. Review of the resident's last PT progress note, completed by Physical Therapy Assistant (PTA) D and dated 9/14/20, showed: -Prior level of function 9/13/20: Patient is able to roll and supine (on back) to sit with maximum assist (75%); -Current level of function: The patient is able to roll and transition sit to supine with near total dependence (90% to 95% assist) and with initiation cue and with 90%. The patient is able to roll and transition sit to supine with visual and tactile instruction/cues; -Skilled services provided since last report: Instructed patient in proper technique with bed mobility to reduce caregiver burden and improve patient independence; -Patient training: Patient education and training provided for bed mobility and the patient was able to follow with 10% accuracy; -Precautions: Falls. Review of a facility investigation for fall with injury report, dated 9/20/20, showed: -The resident requires assistance of one or two persons for bed mobility, depending upon her level of self-performance at the time care is rendered. He/she requires a mechanical lift (device that transfers a resident not capable of bearing weight) and two staff for transfers. On 9/20/20 at 6:00 A.M., resident was being assisted with incontinence care when he/she rolled from the bed onto the floor. Pain noted with range of motion to the left upper extremity. Physician was contacted and an order was obtained for an x-ray of the left arm. X-ray showed a left humeral (upper arm) fracture. Resident sent to hospital for evaluation and treatment. Resident returned from hospital with a sling in place, new orders for pain medication and an orthopedic evaluation; -Resident interview on 9/21/20: The resident stated he/she remembered falling, but not how he/she fell ; -Interview with CNA E said during care of the resident (9/20/20 at 6:00 A.M.), he/she reached for an incontinence brief to put on the resident. The resident moved his/her leg forward and it went off the bed. The resident then rolled forward and off the bed landing on his/her left arm complaining of pain. The CNA said the resident could be handled by one staff member as other instances of assistance of one have been successful to maintain the highest level of independence. He/she did turn the resident while providing care. On 9/21/20 at 9345 A.M., the Director of Nurses (DON) and administrator reported to the survey team the resident's accident from 9/20/20. The DON said the resident required one to two persons for bed mobility and sustained a left humerus fracture. During an interview on 9/21/20 at 10:10 A.M., CNA E said he/she was providing care to the resident the morning of 9/20/20, when the resident rolled off the bed. That was the first day he/she provided care for the resident. Prior to providing care, he/she checked the care tracker system (an electronic system used by CNAs that shows what type of care a resident requires) which showed one or two staff for bed mobility. He/she asked the resident before beginning care if he/she could assist with turning and repositioning, the resident said yes. He/she raised the bed to about the height of his/her hips. The resident was on a bath sheet, which he/she pulled on to turn the resident onto his/her right side. The resident was positioned in the middle of the bed. He/she kept his/her left hand on the resident and reached for an incontinence brief with his/her right hand. It was at that time he/she thinks the resident's left leg shifted or he/she swung his/her leg out causing him/her to roll forward and off the bed. He/she was unable to stop the resident from falling. Review of the resident's care tracker system, showed the facility changed the resident's bed mobility and toileting assistance to two persons on 9/21/20. During observation and interview on 9/22/20 at 10:58 A.M., the resident lay in bed with a sling on his/her left arm/shoulder. The resident said he/she really could not recall what happened the day he/she fell out of bed. One minute he/she was on the bed and the next he/she ended up on the floor. During an interview on 9/22/20 at 11:40 A.M., the therapy program manager said the resident had been discharged from skilled therapy services on 9/17/20. Nursing staff should be constantly assessing residents to determine if more care is required and let them know. She reviewed the last skilled therapy progress note, dated 9/14/20, and said PTA D completed the note. During an interview on 9/22/20 at 11:45 A.M., Occupational Therapist F said he/she had worked with the resident and felt for nursing staff, the resident definitely needed two staff for bed mobility due to the resident's weight. During an interview on 9/22/20 at 11:50 A.M., PTA D said for him/her, the resident was a maximum assistance of one for bed mobility and transfers. He/she felt it was ok for one nursing staff to provide bed mobility. During an interview on 9/22/20 at 12:00 P.M., the DON said the resident's care plan showed he/she needed bed mobility assistance of one or two staff when the resident fell out of bed and sustained the fracture. A resident may need one assist at times and two assist at other times depending on the resident's ability at the time of care. It is up to the CNA to make that determination. MO 745
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, the facility failed to ensure staff used acceptable infection control procedures by wearing the appropriate Personal Protective Equipment (PPE) while providing personal care on the COVID-19 quarantine unit for one resident (Resident #183) and not ensuring staff washed their hands and changed gloves appropriately during wound care for one resident (Resident #232). In addition, staff failed to follow infection control practices regarding mask usage while preparing food and failed to ensure an ice scoop remained covered to prevent contamination. The census was 45. Review of the facility's policy on Infection Control Novel Coronavirus Prevention and Response, updated 7/30/20, showed: -Purpose: To provide direction for the prevention of the novel Coronavirus disease and guidelines should Coronavirus (COVID-19) affect any facility resident or employee; -Policy: The facility will respond promptly upon suspicion of illness associated with a novel Coronavirus in efforts to identify, treat and prevent the spread of [MEDICAL CONDITION]; -Definitions: Coronavirus is [MEDICAL CONDITION] that causes mild to severe respiratory illness; -Resident Care: When COVID-19 status is unknown: Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 (a particle filtering facepiece respirator) or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown (if anticipating droplet exposure during resident care task). 1. Review of Resident #183's entry tracking Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 9/10/20, showed an admission date of [DATE]. Observation on 9/18/20 at 5:32 A.M., showed the resident lay in bed on the quarantine hall. Certified Nursing Assistant (CNA) B entered the room wearing goggles and an N95 mask. After washing his/her hands and applying gloves, he/she provided personal care. He/She failed to apply a disposable isolation gown prior to providing care. During an interview on 9/18/20 at 6:10 A.M., CNA B said he/she should have had a isolation gown on while providing care. During an interview on 9/22/20 at 1:00 P.M., the Director of Nurses (DON) said she would expect the staff to don (apply) an isolation gown prior to providing personal care. 2. Review of the facility's policy on Standard and Transmission Based Precautions, updated 6/2018, showed the following: -Standard Precautions are based on the principle that all blood and body on the principle that all blood and fluids, secretions, excretions, (except) non-intact skin and mucus membrane may contain transmissible infection agents; -Hand hygiene: Remains the single most effective means preventing infections and controlling disease transmission. Wash hands whenever they are soiled with body substance, before starting starting work, before food preparations, before eating, after using the toilet, before and after removing gloves or other protective equipment, before passing medications or performing treatments and when each resident's care is completed. When in doubt, wash your hands; -Gloves: Wear gloves when it can be reasonable to be 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, vomit or items/surfaces soiled with these substances and or persons with a rash. Review of Resident

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) #232's entry tracking MD'S, dated 9/10/20, showed an admission date of [DATE]. Observation on 9/22/20 at 7:00 A.M., showed the resident lay in bed. After washing hands and applying gloves, Nurse C and the DON turned the resident to his/her left side and removed the wet and soiled brief, revealing a dressing to the coccyx. Nurse C cleaned the wound twice with wound cleaner and without changing his/her gloves, or washing his/her hands applied [MEDICATION NAME] (a honey impregnated gel used to remove dead tissue) and a foam dressing. During an interview on 9/22/20 at 7:15 A.M., Nurse C said he/she should have washed his/her hands and changed his/her gloves after cleaning the wound and before applying the treatment. During an interview on 9/22/20 at 7:20 A.M., the DON said she would expect the nurse to remove gloves, clean hands, and reapply clean gloves prior to applying treatment and dressing. 3. Review of the CDC Using PPE, updated August 19, 2020, showed the following: -Facemasks Do's and Don'ts for HCP (Health Care Provider): -When putting on your facemask, clean your hands and put on your facemask so it fully covers your mouth and nose; -Don't wear your facemask under your nose or mouth. Observation on 9/18/20 at 11:33 A.M., showed, Cook G prepared food in the kitchen with a mask on his/her mouth. The mask did not cover his/her nose. Observation on 9/22/20 at 10:50 A.M., showed Cook G prepared food in the kitchen with a mask on his/her mouth. The mask did not cover his/her nose. During an interview on 9/22/20 at 7:18 A.M., the Dietary Manager said kitchen staff should have on masks at all times. The mask should be worn properly, covering the mouth and nose. During an interview on 9/22/20 at 1:10 P.M., the Administrator and DON said masks should be worn properly, covering the mouth and the nose. 4. Observations of the dining room on 9/16/20 through 9/18/20 from 6:30 A.M. to 3:00 P.M. and 9/21/20 from 6:30 A.M. to 3:00 P.M. and 9/22/20 at 7:18 A.M., showed an uncovered ice scoop in a tray next to the sink. During an interview on 9/22/20 at 7:18 A.M., the Dietary Manager said the ice scoop should not be next to the sink, uncovered. Staff could wash their hands and water could splatter onto the ice tray, spreading germs.