| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265479 | A. Building<br>B. Wing | 06/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sikeston Convalescent Center | 103 Kennedy Drive<br>Sikeston, MO 63801 |

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 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on interview and record review, the facility failed to follow their policy to notify the designated resident representative/emergency contact for one resident (Resident #1) out of three sampled residents who had a significant change in condition. The facility census was 72.<br><br>Review of the facility's policy titled, Change in a Resident's Condition or Status, showed:<br><br>- The facility promptly notifies the resident, his/her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status;<br><br>- A nurse will notify the resident's representative when there is a significant change in the resident's physical, mental, or psychosocial status.<br><br>1. Review of Resident #1's medical record showed:<br><br>- admission date of 01/09/24;<br><br>- Diagnoses of diabetes mellitus (a chronic metabolic disorder characterized by abnormally high blood sugar levels), muscle weakness (lack of muscle strength), Alzheimer's (a progressive disease that destroys memory and other mental functions ) disease, anemia (lower number of red blood cells), chronic kidney disease (CKD - a progressive loss of kidney function), and chronic obstructive pulmonary disease (COPD - lung disease that causes persistent airflow obstruction and breathing problem);<br><br>- Severe cognitive impairment;<br><br>- Emergency contact list did not include the family member present at the facility on 05/24/25, as the resident representative/emergency contact.<br><br>Review of the resident's Care Plan, dated 03/31/25, showed:<br><br>- Displayed a deficiency in cognition.<br><br>Review of the resident's Progress Notes, dated 05/23/25, showed:<br><br>- At 5:39 P.M., Certified Medication Technician (CMT) D went into the dining room to administer the resident his/her medication and the resident not responsive as normal. CMT D notified the nurse the resident needed assistance;<br><br>(continued on next page) |

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.

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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - At 5:40 P.M., Licensed Practical Nurse (LPN) F assessed the resident, LPN G assisted LPN F. The resident was lethargic, cold, and not responding as normal. Blood pressure was 112/73, pulse was 30 per radial (inside of wrist), and unable to hear the apical (left side of the chest near the heart) pulse;<br><br>- At 5:47 P.M., LPN F notified emergency medical services (EMS);<br><br>- At 5:54 P.M., EMS arrived to the facility;<br><br>- At 6:00 P.M., report called to the emergency department (ER);<br><br>- At 6:08 P.M., EMS left the facility;<br><br>- No documentation the family/resident representative was notified of the resident's decline in status and transported by EMS to the hospital.<br><br>During an interview on 06/05/25 at 12:45 P.M., Registered Nurse (RN) E said if a change in condition of a resident happened, he/she would look at the face sheet in the electronic health record (EHR) and look for the emergency contact or power of attorney (POA) and notify that person, and if needed, would go down the list of contacts.<br><br>During an interview on 06/05/25 at 12:50 P.M., the Director of Nursing (DON) said she would notify the family by calling the emergency contact, and if no answer. If the resident had a POA, then she would contact that person instead. She expected staff to do the same.<br><br>During an interview on 06/05/25 at 3:40 P.M., the Administrator said a family member of the resident came into the facility before EMS left with the resident. He did not think the resident representative/emergency contact should have been notified since there was a family member in the facility. He would assume the family member would notify the resident representative/emergency contact of the resident's change in status and transfer to the hospital.<br><br>Complaint #254888 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #4 and #5) out of two sampled residents who were incontinent of bladder, received appropriate treatment and services after an incontinent episode which left the residents in urine saturated briefs and with a strong urine odor. The census was 72.<br><br>Review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised April 2025, showed:<br><br>- Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: a.) hygiene (bathing, dressing, grooming, and oral care), b.) mobility (transfer and ambulation, including walking), c.) elimination (toileting), d.) dining (eating, including meals, and snacks), e.) communication (including speech, language, and other functional communication systems);<br><br>- A resident's ability to perform ADLs is measured using clinical tools, including the Minimum Data Sets (MDS - a federally mandated assessment instrument completed by the facility staff).<br><br>The facility did not provide a policy in regards of timing for residents to be assessed for incontinent episodes.<br><br>1. Review of Resident #4's medical record showed:<br><br>- Diagnoses of cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) of the left side, and vascular dementia (dementia caused by impaired blood supply to the brain);<br><br>Review of the resident's quarterly MDS, dated [DATE], showed:<br><br>- Moderate cognitive impairment;<br><br>- Impairment on one side of the upper and lower extremities;<br><br>- Substantial/Moderate assist for sit to stand and transfers;<br><br>- Dependent for toileting hygiene;<br><br>- Frequently incontinent of bladder and always incontinent of bowel.<br><br>Review of the resident's Care Plan, revised 04/30/25, showed:<br><br>- Required extensive assist with ADLs;<br><br>- Incontinent of bowel and bladder and required assistance with toileting.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation of the resident's incontinent care on 06/05/25 at 12:22 P.M., showed:<br><br>- Nurse Aide (NA) A and Certified Nurse Aide (CNA) B, and CNA C performed hand hygiene and put on gloves;<br><br>- NA A and CNA B unfastened the the resident's urine saturated brief with a strong urine odor;<br><br>- CNA B washed the resident's buttocks and the back of the legs;<br><br>- CNA B did not clean the resident's pelvic and groin areas;<br><br>- NA A and CNA B placed a clean brief on the resident and covered the resident with a sheet and blanket.<br><br>2. Review of Resident #5's medical record showed:<br><br>- Diagnoses of Parkinsonism (tremor, slow movements, rigidity, and postural instability), ataxia (impaired balance and movement), spinal stenosis (narrowing of spinal canal), and hemiplegia and hemiparesis of left non-dominant side;<br><br>Review of the resident's quarterly MDS, dated , 04/01/25, showed:<br><br>- Moderate cognitive impairment;<br><br>- No impairment of the upper and lower extremities;<br><br>- Partial/ Moderate assist for sit to stand and transfers;<br><br>- Dependent for toileting hygiene;<br><br>- Occasionally incontinent of bladder and always incontinent of bowel.<br><br>Review of the resident's Care Plan, dated, 04/13/25, showed:<br><br>- Required extensive assist with ADLs;<br><br>- Incontinent of bowel and bladder and required assistance with toileting.<br><br>Observation of the resident's incontinent care on 06/05/25 at 12:37 P.M., showed:<br><br>- NA A and CNA B performed hand hygiene and put on gloves;<br><br>- NA A and CNA B unfastened the resident's urine saturated brief with a strong urine odor;<br><br>- NA A cleaned the resident's buttocks and the backs of the legs;<br><br>- NA A removed the urine saturated brief and placed a clean brief under the resident;<br><br>- NA A and CNA A did not clean the resident's pelvic and groin areas;<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - NA A and CNA B fastened the clean brief and covered the resident with a sheet and blanket.<br><br>During an interview on 06/05/25 at 1:51 P.M., Resident #5 said he/she was not changed before lunch and that was why he/she had a urine saturated brief. The staff had changed him/her at least twice today. Staff did come around and checked him/her but didn't know how often.<br><br>During an interview on 06/05/25 at 1:40 P.M., Resident #6 said he/she was able to use the call light if he/she felt wet but said that he/she waited a long time for them to check. He/She couldn't always tell when he/she was incontinent so depended on the staff to check him/her.<br><br>During an interview on 06/05/25 at 1:52 P.M., Resident #8 said he/she had been wet for over an hour. He/She had pushed his/her call light, staff entered the room, turned off the light, said they you would get help, and never returned.<br><br>During an interview on 06/05/25 at 1:55 P.M., Resident #7 said he/she had his/her call light on at this time. He/She needed assistance with care and wanted to go to bed. Staff would come in the room, turn the light off, and would not return sometimes to help him/her.<br><br>During an interview on 06/05/25 at 1:39 P.M., the Infection Preventionist said staff should clean the front and peri areas when performing incontinent care to residents.<br><br>During an interview on 06/05/25 at 2:51 P.M., the Director of Nursing said residents should be checked every two hours if they were incontinent and changed if they were soiled. If residents were non-verbal, residents should be checked at least every hour. When staff were performing incontinent care, the front and back peri areas should be cleaned before a clean brief was placed secured.<br><br>During an interview on 06/05/25 at 2:51 P.M., the Administrator said that there was no regulation stating how often residents were to be checked for incontinence. It was a standard of practice to check the residents every two hours.<br><br>During an interview on 06/09/25 at 11:05 A.M., CNA B said that he/she was unaware that any mistakes were made during the incontinent care given to the residents. All soiled areas of the resident should be cleaned before putting on a clean brief.<br><br>Complaint #254888 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform hand hygiene, change gloves and provide appropriate incontinent care for two residents (Resident #4 and #5) out of two sampled residents who were incontinent of bladder. The census was 72.<br><br>The facility did not provide a policy addressing infection control practices during incontinent care.<br><br>1. Review of Resident #4's medical record showed:<br><br>- Diagnoses of cerebral infarction (stroke), hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body) of the left side, and vascular dementia (dementia caused by impaired blood supply to the brain).<br><br>Review of the resident's quarterly MDS, dated [DATE], showed:<br><br>- Moderate cognitive impairment;<br><br>- Impairment on one side of the upper and lower extremities;<br><br>- Substantial/Moderate assist for sit to stand and transfers;<br><br>- Dependent for toileting hygiene;<br><br>- Frequently incontinent of bladder and always incontinent of bowel.<br><br>Review of the resident's Care Plan, revised 04/30/25, showed:<br><br>- Required extensive assist with ADLs;<br><br>- Incontinent of bowel and bladder and required assistance with toileting.<br><br>Observation of the resident's incontinent care on 06/05/25 at 12:22 P.M., showed:<br><br>- Nurse Aide (NA) A and Certified Nurse Aide (CNA) B and CNA C performed hand hygiene and put on gloves;<br><br>- NA A and CNA B unfastened the resident's urine saturated brief, did not change gloves, and did not perform hand hygiene;<br><br>- CNA B washed the resident's buttocks and the back of the legs;<br><br>- CNA B removed the urine saturated brief, did not perform hand hygiene, and did not change gloves;<br><br>- CNA B placed a clean brief under the resident;<br><br>- NA A and CNA B secured the clean brief, removed gloves, and performed hand hygiene.<br><br>(continued on next page) |

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