STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265492	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chaffee Nursing Center	12273 State Highway 77 Chaffee, MO 63740

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review, the facility failed to identify, assess and provide supportive interventions for one resident (Resident #8) with a diagnosis of post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts to the event) out of one sampled resident. The facility's census was 59. Review of the facility's policy titled, Trauma Informed Care, undated, showed: - It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization; - The facility will work to facilitate the principles of trauma informed care which includes collaboration between resident and/or his or her representative, and all staff and disciplines involved in the resident's care in developing the plan of care; - The facility will ask the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools; - The facility will identify triggers which may re-traumatize resident with a history of trauma, trigger specific interventions will identify ways to decrease the resident's exposure to triggers; - Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety; - The facility will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers; - In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. 1. Review of Resident #8's medical record showed: - admission date of 02/17/15; (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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of PTSD, depression (a serious medical illness that negatively affects how you feel, the way you think and how you act), insomnia (difficulty falling or staying asleep, resulting in poor sleep quality), and anxiety disorder (persistent worry and fear about everyday situations); - No trauma informed care assessment. Review of the resident's Physician's Order Sheet (POS), dated February 2025, showed: - An order for Lexapro (an antidepressant medication) 10 milligrams (mg) by mouth at bedtime for depression, dated 12/20/22; - An order for trazodone (an antidepressant medication) 100 mg by mouth at bedtime for insomnia, dated 03/06/24; - An order for psychological services, dated 01/21/2021. Review of the resident's comprehensive care plan, last revised 02/18/25, showed: - PTSD not addressed; - No goals to maintain the resident's psychosocial and mental health; - No documentation of the resident's past trauma, or any triggers that would cause the resident trauma; - No interventions for how the facility would address the behaviors if they occurred or how the facility would provide support to the resident. During an interview on 02/24/25 at 2:30 P.M., the resident said he/she has experienced trauma, a heat stroke, and gets upset if he/she hears people talking about him/her. During an interview on 02/25/25 at 3:06 P.M., the Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) Coordinator said PTSD should be on the care plan if it is active. During an interview on 02/26/25 at 9:55 A.M., the Social Service Designee (SSD) said he/she was unaware of any triggers for the resident, if someone asks him/her to go outside when it is hot outside, the resident will say no, due to having a heat stroke in the past. During an interview on 02/27/25 at 12:14 P.M., the Director of Nursing (DON) and the Administrator said PTSD and triggers should be on the care plan if it is active.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) during medication administration. There were 27 opportunities with two errors made, for an error rate of 7.41%, which affected one resident (Resident #4) out of three sampled residents. The facility's census was 59. Review of the facility's policy titled, Administering Oral Medications, reviewed May 2019, showed: - Check the label on the medication and confirm the medication name and dose with the Medication Administration Record (MAR); - Check the medication dose, re-check to confirm the proper dose. Review of the facility's policy titled, Adverse Consequences and Medication Errors, reviewed May 2019, showed: - A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services; - Examples of medication errors includes wrong dose and wrong dosage form. 1. Review of Resident #4's Physician's Order Sheet (POS), dated February 2025, showed: - An order for aspirin 81 milligrams (mg) chewable in the morning, dated 11/26/24; - An order for Fluticasone Propionate Nasal Suspension (a medication used to treat inflammation of the nasal passages) 50 micrograms (mcg) per actuation (ACT), two sprays in both nostrils in the morning, dated 11/26/24. Observation of the resident's medication administration on 02/26/25 at 7:58 A.M. showed: - Registered Nurse (RN) E administered aspirin 81 mg enteric coated to the resident; - RN E administered Fluticasone Propionate Nasal Suspension one spray in both nostrils to the resident. During an interview on 02/26/25 at 8:15 A.M., RN E said he/she should have confirmed the dosage of nasal spray before giving it and should have given the chewable form of aspirin instead of the enteric coated tablet. During an interview on 02/27/25 at 1:14 P.M., the Administrator and the Director of Nursing (DON) said they expect to have a medication error rate less than five percent.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, facility staff failed to maintain appropriate infection control practices by not performing proper hand hygiene and glove changing techniques during incontinent care and medication administration for two residents (Resident #27 and #214) out of 15 sampled residents and two residents (Resident #4 and #37) outside the sample and failed to provide infection prevention precautions by not following enhanced barrier precautions (EBP) for one resident (Resident #15) out of six sampled residents. The facility's census was 59. Review of the facility's policy titled, Personal Protective Equipment, dated May 2024, showed: - Change gloves and perform hand hygiene between clean and dirty tasks and when moving from one body part to another; - Perform hand hygiene before donning gloves and after removal. Review of the facility's policy titled, Perineal Care, dated May 2019, showed: - Wash perineal area, wiping from front to back; - Continue to wash the perineum moving from inside outward; - Do not reuse the same washcloth or water to clean the urethra; - After washing perineal area, wash the rectal area thoroughly. Review of the facility's policy titled, Suprapubic Catheter Care, dated May 2019, showed: - Wash around the catheter site with soap and water or peri wash; - If the resident has a drainage sponge around the stoma site, remove the drainage sponge before washing with soap and water. Review of the facility's policy titled Enhanced Barrier Precautions, last revised on 11/25/24, showed: - All staff receive training on enhanced barrier precautions upon hire and at least annually and are expected to comply with all designated precautions; - An order for enhanced barrier precautions will be obtained for residents with wounds and/or indwelling devices; - Personal Protective Equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities; - High-contact care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care, and wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Observation on 02/26/25 at 7:58 A.M. of Resident #4's medication administration showed: - Registered Nurse (RN) E dropped a Jardiance (a medication used to control blood sugar) pill onto the top of the medication cart, picked up the dropped pill with bare fingers, and placed the pill into medication cup, contaminating the medication and the other medications in the cup; - RN E dropped a methocarbamol (a muscle relaxant medication) pill onto the top of the medication cart, picked up the dropped pill with bare fingers, and placed the pill into the medication cup, contaminating the medication and the other medications in the cup; - RN E administered the contaminated medications to the resident; - RN E checked the resident's blood pressure; - RN E checked for swelling of the resident's legs, by placing his/her bare hand on the resident's lower legs; - RN E left the room, documented the blood pressure reading in the computer and began the next medication administration without performing hand hygiene. 2. Observation on 02/26/25 at 8:09 A.M. of Resident #214's medication administration showed: - RN E, without performing hand hygiene, placed the resident's medications into a medication cup; - RN E handed the resident his/her glasses; - RN E removed the resident's straw from one cup and placed it into a cup of water with his/her bare fingers without performing hand hygiene or wearing gloves; - RN E repositioned the resident in bed; - RN E gave the resident his/her medications and drink, and left the room; - RN E touched the medication cart and computer without performing hand hygiene. 3. Observation on 02/27/25 at 10:00 A.M. of Resident #27's catheter care showed: - Certified Nurse Aide (CNA) A and CNA B washed hands and donned gowns and gloves; - CNA A opened clean bed protector and laid it across the bedside table; - CNA B made one basin of soapy water and one basin of clean water and sat them on top of the bed protector; - CNA B put clean wash cloths in each basin and left some dry cloths in a bag sitting on the bed protector; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA A took a cloth from the soapy water basin, wrang out, and wiped outer perineal area front to back on each side, folding cloth each time; - CNA A placed the soiled cloth in the dirty linen bag; - Without changing gloves or performing hand hygiene, CNA A reached into the clean soapy water, pulled out another cloth and wrang it out over the basin; - CNA A wiped the area around the catheter, folded cloth, and wiped peri area from side to side; - CNA A placed the soiled cloth in the dirty linen bag; - Without changing gloves or performing hand hygiene, CNA A reached into the clean soapy water and pulled out another cloth and wrang it out over the basin; - CNA A wiped the catheter starting closest to the insertion point and wiped away from the body approximately four inches, folded cloth and repeated; - CNA A placed the soiled cloth in the dirty linen bag; - Without changing gloves or performing hand hygiene, CNA A reached into the clean soapy water, pulled out another cloth and wrang it out over the basin; - CNA A wiped down the resident's left inner thigh, folded cloth, and wiped the right inner thigh; - Without changing gloves or performing hand hygiene, CNA A reached into the clean water, pulled out a cloth and wrang it out over the basin; - CNA A wiped the area around the catheter, folded cloth, and wiped peri area front to back from the outside in, folding the cloth with each pass; - CNA A placed the soiled cloth in the dirty linen bag; - Without changing gloves or performing hand hygiene, CNA A reached into the clean water, pulled out another cloth and wrang it out over the basin; - CNA A wiped down the catheter starting from the insertion point and moving outward, folded cloth and repeated; - CNA A placed the soiled cloth in the dirty linen bag; - CNA B handed CNA A a clean dry cloth; - CNA A dried the resident's peri area moving front to back; - Without changing gloves or performing hand hygiene, CNA A without changing gloves or performing hand hygiene, reached into the clean bag and pulled out a clean dry cloth; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA A dried the resident's inner thighs and then pulled the covers up to the resident's waist; - Without changing gloves or performing hand hygiene, CNA A reached into the soapy water, pulled out a cloth, wrang it out over the basin and handed it to the resident to wash his/her hands; - CNA B took a clean dry cloth, wet it in the sink and handed it to the resident to rinse his/her hands; - CNA A removed gloves; - Without performing hand hygiene, CNA A pulled a clean dry cloth from the bag and handed it to the resident to dry his/her hands; - CNA B emptied the basins into the sink, removed gown and gloves, and washed hands with soap and water; - CNA A removed gown and placed in trash can, gathered trash and dirty linens and left the room; - CNA B cleaned the bed side table with a wet soapy paper towel, then a wet paper towel; - CNA B dried the bed side table with a paper towel, placed the resident's cup and phone on the table and left the room. 4. Observation on 02/27/25 at 12:58 P.M. of Resident #37's perineal care showed: - CNA C made a basin of soapy water and sat it on the resident's bed side table; - Without performing hand hygiene, CNA C donned gloves; - CNA D washed hands and donned gloves; - CNA D placed bed protector on the bed under the resident's hips; - CNA D rolled the resident onto his/her right side, removed the soiled brief, and placed in trash can; - CNA C handed CNA D a clean cloth from the soapy water basin; - CNA D wiped the resident's buttock front to back, folded cloth, wiped front to back, folded cloth, repeated one more time, and placed the soiled cloth in the dirty linen bag; - Without changing gloves or performing hand hygiene, CNA D placed a clean incontinence brief under the resident and rolled the resident onto his/her back; - CNA C handed CNA D a clean cloth from the soapy water basin; - CNA D wiped the resident's perineal area from back to front; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- CNA D placed the soiled cloth in the dirty linen bag; - CNA C handed CNA D a clean dry cloth; - Without changing gloves or performing hand hygiene, CNA D used the clean dry cloth to dry the resident's perineal area; - CNA D placed the soiled cloth in the dirty linen bag; - Without changing gloves or performing hand hygiene, CNA D closed resident's incontinence brief; - CNA D removed gloves and washed hands with soap and water; - CNA C removed gloves and placed pants on the resident. 5. Review of Resident #15's medical record showed; - An admission date of 07/18/24; - An order to clean lumbar wound with wound cleanser and cover with Mepilex (absorbent dressing) until healed, every day shift, dated 02/24/25. Observation of the resident on 02/26/25 at 11:56 A.M. showed: - A sign on the resident's name plate by the door stating EBP; - CNA A and CNA B entered the room, did not perform hand hygiene, and did not don gloves or gowns; - CNA A placed the resident's upper mechanical lift sling straps on the mechanical lift, touching the bed with his/her clothes; - CNA B placed the lower mechanical lift sling straps on the mechanical lift, touching the bed with his/her clothes; - CNA B placed socks on the resident; - CNA A raised the mechanical lift and positioned the resident over the wheelchair; - CNA B positioned the resident in the wheelchair; - CNA A brushed the resident's hair; - CNA B made the resident's bed; - CNA B transferred the resident to the dining room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/25 at 8:15 A.M., RN E said he/she should have performed hand hygiene between residents and should have destroyed the dropped medications and administered new medications. During an interview on 02/26/25 at 12:10 P.M., CNA A and CNA B said they should have worn gloves and a gown during the care of the resident who required EBP. During an interview on 02/27/25 at 1:10 P.M., CNA D said gloves should be changed and hand hygiene performed before going from dirty activity to clean activity. He/She said perineal care should be performed from front to back. During an interview on 02/27/25 at 2:14 P.M., the Director of Nursing (DON) and Administrator both said they would expect staff to follow EBP during high contact resident care activities, gloves to be changed and hand hygiene to be performed when going from dirty to clean, and for perineal care to be performed from front to back.