STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265614	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview Nursing Center	430 Salcedo Road 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)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to respond or act upon grievances, and failed to keep documentation of inventory for two residents (Residents #23 and #48) out of 15 sampled residents. The facility census was 59. Review of the facility's policy titled, Grievance Protocol, undated, showed: - The purpose of the grievance/complaint report and grievance log is to provide a written record of each resident and family concern and to insure proper follow-up through the appropriate discipline; - The Social Service Director (SSD) is responsible for the program, although the Administrator is ultimately responsible for the proper implementation; - Grievance complaint should be filled out for resident articles that are lost or cannot be located; - Social Services and Administrator evaluate the monthly grievance log for trends or patterns and devise an action plan to correct issues. A new log should be completed each month. The facility did not provide an inventory policy. Review of the facility's Grievance Log showed an empty binder with no documentation of any reported resident grievances. During an interview on 12/03/24 at 1:59 P.M., Resident #48 said he/she was missing an electronic tablet and a cell phone. The items went missing within the last two - three weeks. He/She made the SSD and the Administrator aware of the missing items, but they were not doing anything about it. During an interview on 12/04/24 at 9:16 A.M., the SSD said he/she was not aware of Resident #48's missing items until 12/02/24, and did not initiate a grievance related to the incident. He/She helped the resident look through his/her room for the missing items, but they were not found. The facility did not have inventory sheets for the resident's belongings, but he/she did normally try to get inventory lists completed for the residents. SSD had not been initiating or completing grievances. During an interview on 12/04/24 at 10:11 A.M., Resident #23 said he/she was missing a cereal cup full of quarters and two electronic tablets. One tablet had been missing longer than a year, but the second tablet and cup of quarters were missing within the past two months. He/She told the SSD about the missing items and had never heard anything else about them. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/04/24 at 10:42 A.M., the SSD said he/she did remember hearing about the missing money for Resident #23, but did not remember anything about a missing tablet. The SSD told the resident it was safer to keep money in the front business office. The SSD did not initiate or complete a grievance for the reported incident and did not have an inventory sheet for Resident #23. SSD said there should be a grievance form filled out when a resident reports a concern and an inventory sheet completed for each resident at the facility. During an interview on 12/04/24 at 11:15 A.M., Certified Nursing Assistant (CNA) G said he/she did know about the items missing for Resident #48. Any time items were reported missing by a resident, he/she will help search and then notify the charge nurse on duty. During an interview on 12/04/24 at 11:01 A.M., Registered Nurse (RN) F said he/she was aware that Resident #48 had missing items. When staff were told items were missing, he/she will help search and make the Director of Nursing (DON) aware. During an interview on 12/04/24 at 11:08 A.M., the DON said she was aware of the missing items for Resident #23 and Resident #48. When items were reported missing, there should be an investigation started immediately and inventory sheets reviewed. During an interview on 12/04/24 at 10:45 A.M., the Administrator said he was unsure about the grievance policy, but they did work together as a team to try and handle missing items. He had never replaced items for residents in the past.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a physician's order for code status for two residents (Residents #14 and #38) and consistently document a resident's code status with Full Code (cardiopulmonary resuscitation (CPR - an emergency procedure consisting of chest compressions if the heart stops beating or the person stops breathing) or Do Not Resuscitate (DNR - does not want CPR) for one resident (Resident #35) out of 15 sampled residents. The facility census was 59. Review of the facility's policy titled, DNR Protocol, not dated, showed: - The Social Services Designee (SSD) will be responsible to print all DNR order forms on lavender paper to be placed in the admission packet; - Once the DNR form is signed by the resident or legal representative it is to be signed by the physician; - The SSD will then complete the following: a green paper with Full Code or a red paper with DNR will be placed in the very front of the medical record in a plastic sheet protector; on the Physician Order Sheet (POS) in the menu section located in the right upper corner of the POS, the SSD will add the heading of Code Status; - The resident's code status will be periodically reviewed and renewed with the resident and/or legal representative, no less than quarterly during care plan review with the resident or resident's representative signing the care plan; - The SSD will monitor the resident code status monthly, with new admission, readmissions, and as a resident's code status is changed to ensure all components of the program are current. 1. Review of Resident #14's medical record showed: - admission date of [DATE]; - Face sheet with Full Code status; - Full Code written on spine of the hard chart. Review of the resident's [DATE] Physician Order Sheet (POS) showed: - No order for the resident's code status. Review of the resident's revised care plan, dated [DATE], showed: - Full Code status. 2. Review of Resident #35's medical record showed: (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- admission date of [DATE]; - Face sheet with DNR code status; - A red dot for DNR on the spine of the hard chart. Review of the resident's [DATE] POS showed: - An order for Full Code status. Review of the resident's revised care plan, dated [DATE], showed: - Full Code status. 3. Review of Resident #38's medical record showed: - An admission date of [DATE]; - Face sheet with Full Code status; - A green dot for Full Code on the spine of the hard chart. Review of the resident's [DATE] POS showed: - No order for the resident's code status. Review of the resident's revised care plan, dated [DATE], showed: - Full Code status. During an interview on [DATE] at 10:20 A.M., the Director of Nursing (DON) said the Social Service Director (SSD) made sure what the code status was at admission. An order should be obtained for the code status. She would expect the code status to match anywhere it was documented. During an interview on [DATE] at 10:25 A.M., Licensed Practical Nurse (LPN) I said if there was a code called, he/she would look at the hard chart and see what the code status was. A green dot on the spine of the binder meant the resident was a Full Code. A red dot on the spine of the binder meant the resident was a DNR. The face sheet and a purple sheet should be in the chart when the resident was a DNR. During an interview on [DATE] at 10:33 A.M., the MDS (a federally mandated assessment instrument completed by the facility staff) Coordinator said the SSD will let staff know if a resident had changed his/her mind and/or if the code status changed. The SSD would change the face sheet, however the SSD couldn't write an order. The resident was a full code until the DNR paperwork had been signed by the physician. During an interview on [DATE] at 10:40 A.M., the Quality Assurance (QA) Nurse and the DON said they would expect the orders for the code status to be on the physician orders.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 59. The facility did not provide a homelike environment policy. 1. Observations on 12/03/24 at 2:42 P.M., and 12/04/24 at 9:20 A.M., of the 100 Hall showed: - A seat cushion cover worn with several peeled areas on a chair next to the bed near the door in room [ROOM NUMBER]; - Several areas of wallpaper peeled with exposed sheetrock located behind the bed near the window in room [ROOM NUMBER]; - A seat cushion cover worn with several peeled areas on a chair next to the bed near the door in room [ROOM NUMBER]; - Dark scuff marks and a three inch (in.) area of exposed sheetrock and peeled paint on the wall next to the door in room [ROOM NUMBER]. 2. Observations on 12/05/24 at 10:37 A.M., of the 300 Hall showed: - A loose and cracked piece of molding on the right side of the door frame in room [ROOM NUMBER]; - A cracked piece and a missing piece of molding on the left side of the door frame in room [ROOM NUMBER]; - An area of loose sheetrock tape on the ceiling by the privacy curtain track near the bed by the door in room [ROOM NUMBER]; - A seat cushion cover worn with a large area of peeled material on a chair next to the bed near the door in room [ROOM NUMBER]. 3. Observations on 12/06/24 at 12:45 P.M., of the Spa Room next to the mechanical room showed: - Several bed mattresses stacked against the wall by the toilet; - Several cupcake pans stacked on top of the left side clothes cabinet; - A mattress, step ladder and other miscellaneous items stacked against the left side of the clothes cabinet; - Cluttered shower chairs, a red trash can with lid, and miscellaneous debris inside and on the shower stall floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Maintenance Log Book, dated 09/20/24 - 12/02/24, showed no documentation of areas of concern addressed. During an interview on 12/03/24 at 10:23 A.M., the resident in room [ROOM NUMBER] said he/she would like for his/her chair to be either replaced or fixed. He/She doesn't know why staff would take a good chair out of his/her room and replace it with one that looked so bad because he/she had visitors that sit in the chair and it's not very appealing to look at. During an interview on 12/06/24 at 9:05 A.M., Housekeeper C said he/she verbally told the maintenance department if there was something that needed to be fixed. He/She did not know if there was a maintenance log and had not seen anything recently to report other than a toilet not working. During an interview on 12/06/24 at 9:20 A.M., Housekeeper D said if he/she noticed something that needed fixed, he/she let someone know on the hall. He/She had not seen anything to report and was not aware of a maintenance log to write down any environment concerns. During an interview on 12/06/24 at 9:32 A.M., the Maintenance Supervisor (MS) said it would be easier to keep up with environmental issues if staff would write the concerns found on the maintenance log. MS had asked staff to write down the environment concerns because it made it hard to remember things throughout the day when staff didn't write environmental concerns down to be addressed and prioritized in a timely manner. During an interview on 12/06/24 at 10:50 A.M., the Quality Assurance (QA) nurse said the facility had several chairs in storage that could replace the worn chairs. He/She would let the Administrator know. During an interview on 12/06/24 at 12:41 P.M., the Administrator said he would expect staff to use the maintenance log book located at the nurses' station to write down any environmental concerns in addition to verbally telling the MS.

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	265614	A. Building B. Wing	12/06/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff) for two residents (Residents #4 and #51) out of 15 sampled residents. The facility census was 59. Review of the facility's policy titled, MDS and Care Planning Guidelines, revised 10/01/15, showed: - It is the policy of this facility to use the most current Centers for Medicare and Medicaid Services (CMS) MDS Resident Assessment Instrument (RAI - a tool used to assist facility staff to gather defined information on a resident's strengths and needs) Manual, any published interim RAI manual errata (error) documents, and applicable federal guidelines as the authorative guide for completion of MDS, care area assessments (CAAs) and resident care planning; - The policy did not address the accuracy of MDS assessments. 1. Review of Resident #4's annual MDS, dated [DATE], showed: - The resident did not receive an anticoagulant (medication to prevent and treat blood clots in the blood vessels and the heart). Review of the resident's December 2024 Physician Order Sheet (POS) showed: - Diagnosis of personal history of thrombophlebitis (vein inflammation that happens in connection with one or more blood clots); - An order for desmopressin (an anticoagulant) 0.1 milligram (mg) 1/2 tablet oral twice daily, dated 12/05/22; Review of the resident's care plan, revised 02/12/24, showed: - The resident received anticoagulant therapy. 2. Review of Resident #51's annual MDS, dated [DATE], showed: - The resident received an anticoagulant. Review of the resident's December 2024 POS showed: - Diagnosis of stroke; - An order for aspirin (a nonsteroidal anti-inflammatory drug) 325 mg oral daily, dated 12/28/22. Review of the resident's care plan, revised 10/24/24, showed: - The resident received anticoagulant therapy. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/24 at 9:12 A.M. , the MDS Coordinator said if a resident took an anticoagulant, it should be indicated on the resident's MDS assessment. If a resident didn't take an anticoagulant, it should not be indicated as an anticoagulant on the resident's MDS assessment. During an interview on 12/06/24 at 10:18 A.M. , the Director of Nursing (DON) said if a resident took an anticoagulant, it should be indicated on the resident's MDS assessment. If a resident didn't take an anticoagulant, it should not be indicated as an anticoagulant on the resident's MDS assessment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to provide a Preadmission Screening and Resident Review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder, to determine the level of care needed) for two residents (Residents #4 and #43) out of two sampled residents. The facility census was 59. The facility did not provide a policy for a PASARR. 1. Review of Resident #4's medical record showed: - An admission date of 03/16/21; - Diagnoses of dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning) and post traumatic stress disorder (PTSD - psychological distress following a traumatic event); - No documentation of the required level one PASARR screening upon admission to the facility. 2. Review of Resident #43's medical record showed; - An admission date of 01/08/20; - Diagnoses of bipolar (a mental disorder that causes unusual shifts in mood) and schizophrenia (a long term mental disorder that affects a person's ability to think, feel, or behave clearly, sometimes including delusions or hallucinations); - No documentation of the required level one PASARR screening upon admission to the facility. During an interview on 12/05/24 at 11:15 A.M., the Social Service Director (SSD) said a level one PASARR should be completed on a resident prior to admission to the facility. Resident #4's level one screening still needed to be completed and submitted. Resident #43's level one screening was rejected due to no psychiatric documentation that wasn't sent. During an interview on 12/06/24 at 1:05 P.M., the Administrator said he would expect a resident to have a level one PASARR completed prior to the resident being admitted to the facility.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to implement, monitor, and modify interventions to maintain acceptable parameters of nutritional status for one resident(Resident #14) out of two sampled residents. The facility census was 59. Review of the facility's policy titled, Weight Champion Program, not dated, showed: - Each community should designate a weight champion to assist in the oversight and monitoring of residents that have or are at risk for weight loss; - The purpose of this program is to take a proactive stance against weight loss and collaborate to decrease weight loss numbers; - The weight champion will be responsible for keeping the weight variance report from Matrix, as well being custodian of the daily, weekly and monthly facility weight lists; - The champion will review for completion during the next stand up meeting. The champion will request and monitor re-weights of residents; - Weights should be reviewed weekly in our Interdisciplinary Team (IDT) meeting; - Weights should be assessed by the IDT at the time that the loss is noted. If a supplement is necessary, food items should be tried first, the exception is that of those resident drinking is more feasible for the resident. This must be documented; - Examples of food interventions are snacks, fortified (a fortified food used to provide extra calories, proteins and vitamins) milk , fortified soups, extra portions, supercereal (a fortified cereal used to provide extra calories, proteins and vitamins), smaller more frequent meals, super pudding (a fortified pudding used to provide extra calories, proteins and vitamins), fortified food program. Review of the facility's policy titled, Registered Consultant Dietitian (RD), dated May 2015, showed: - Monthly visits to each facility to assist in compliance of regulatory requirements in food service and residents' dietary care with a report of findings; - Consultation with the Director of Nursing (DON) on all residents who are at risk for poor nutrition, have significant weight loss, have pressure sores, or that are fed per tube. 1. Review of Resident #14's Physician Order Sheet (POS), dated December 2024, showed: - An order for Level 7 Regular diet (easy to chew), reduced concentrated sweets (RCS), dated 06/21/24; - An order for Boost very high calorie drink (VHC) 120 millimeters (ml) with supper meal, dated 12/03/24; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- An order for a referral to gastroenterologist (specialist in organs of the digestive system), dated 12/04/24; - No order for a multivitamin as recommended by the RD on 06/18/24; - No order for weekly weights as recommended by the RD on 12/03/24. Review of the resident's Weight Variance Report, dated 06/15/24 through 12/04/24, showed: - On 06/15/24, the resident weighed 235.8 pounds (lbs); - On 06/20/24, the resident weighed 235.8 lbs; - On 06/25/24, the resident weighed 233.7 lbs; - On 07/02/24, the resident weighed 233.7 lbs; - On 07/09/24, the resident weighed 230.4 lbs; - On 08/02/24, the resident weighed 228.0 lbs; - On 09/03/24, the resident weighed 221.0 lbs; - On 10/01/24, the resident weighed 216.9 lbs; - On 11/04/24, the resident weighed 210.4 lbs; - On 12/04/24, the resident weighed 206.6 lbs; - From 06/15/24 - 08/02/24, the resident had a 4.98% weight loss in 3 months; - From 06/15/24 - 12/04/24, the resident had a 10.38% weight loss in 6 months. Review of the Dietary assessments showed: - An initial assessment completed on 06/18/24, with a regular diet,restricted concentrated sweets, and recommendations to add a multivitamin; - A quarterly nutrition review completed on 09/12/24, with a regular diet and restricted concentrated sweets. Notes weight was down six pounds in 30 days, edema (swelling) contributing; - A significant weight change in status completed on 12/03/24, with greater than 7.5% wt. loss in 90 days. Resident with significant weight change for 90 days and 180 days. Recommended to add VHC 120 ml to supper meal and monitor weekly weights; - No documentation the RD assessed the resident in October and November 2024. Review of the resident's Care Plan, last reviewed, 09/23/24, showed: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A regular diet, no concentrated sweets; - Did not address weight loss with interventions. Observations of the resident on 12/03/24, 12/05/24, and 12/06/24, during the lunch meal showed: - The resident ate in the main dining room. The resident #14 ate approximately 50-100% of his/her meals. During an interview on 12/03/24 at 2:14 P.M., Resident #14 said he/she was not trying to lose weight and was not on any medications to aid in weight loss. During an interview on 12/05/24 at 3:25 P.M., the Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) Coordinator said the Restorative Nurse Aide (RNA) weighed the residents. The MDS Coordinator and the DON received a copy of the weight variance report and reviewed it. The facility did not have meetings where they discussed residents weights. During an interview on 12/05/24 at 3:34 P.M. the Quality Assurance (QA) Nurse said the RD needed to be reviewing any weight loss in the facility. The weight variance report should be reviewed by the DON and any resident with weight loss should be seen by the RD. During an interview on 12/11/24 at 9:53 A.M., the RD said it would be good if the facility held weight meetings within the facility on a bi-weekly basis. During an interview on 12/11/24 at 10:30 A.M., the MDS Coordinator said Resident #14's family brought it to the attention of the facility of the resident's weight loss.

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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 a medication error rate of less than five percent (%). There were 37 opportunities with three errors made, resulting in an error rate of 8. 11% for three residents (Residents #20, #34 and #38) out of eleven sampled residents. The facility's census was 59. Review of the facility's policy titled, Specific Medication Administration Procedures, dated July 2021, showed: - Prime insulin pen prior to use; - Dial up two units; - Hold pen upright and push the button on the end of the pen so a small drop of insulin appears; - Dial insulin to the desired insulin dose to be administered to the resident. Review of the Humalog/lispro (a rapid insulin injected just below the skin that helps lower mealtime blood sugar spikes) Kwik Pen (Insulin in a pen-type device) instructions, revised, July 2023, showed: - Prime the pen by turning the dose knob to two units; - Hold the pen with the needle pointing up; - Tap the cartridge holder gently to collect air bubbles at the top; - Push the dose knob in until it stops, and zero is seen in the dose window, count to five slowly, insulin will be visible at the tip of the needle; - Select the dose; - Give the injection after selecting the area and cleaning the site with an alcohol swab. Review of the Novolog/Fiasp/aspart (fast-acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen administration instructions, dated September 2021, showed: - Prime the pen by turning the dose selector to two units; - Keep the needle upwards and press the push-button until the dose selector reads zero; - Turn the dose selector to select the number of prescribed units. 1. Review of Resident #20's Physician Order Sheet (POS), dated December 2024, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265614	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview Nursing Center	430 Salcedo Road Sikeston, MO 63801

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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	- An order for Humalog insulin pen 100 units per milliliter (ml) subcutaneous (injection under the skin) with meals per a sliding scale if blood sugar is 151-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, 401-450=12 units, blood sugar greater than 450, call the physician, dated 06/10/24. Observation of Resident #20's medication administration on 12/04/24 at 11:16 A.M., showed: - Registered Nurse (RN) J administered 12 units of Humalog subcutaneously per order of the sliding scale for a blood sugar of 433 with the resident's Humalog Kwik Pen; - RN J failed to prime the Humalog Kwik Pen per the manufacturer's instructions prior to the administration to the resident. 2. Review of Resident #34's POS, dated December 2024, showed: - An order for ondansetron (anti-nausea medication) 4 milligrams (mg) disintegrating tablet three times daily with meals for weight loss, dated 04/10/23. Observation of Resident #34's medication administration on 12/05/24 at 11:30 A.M., showed: - Certified Medication Technician (CMT) K administered the tablet with water; - CMT K failed to instruct the resident to hold the medication on or underneath the tongue for medication to be effective; - The resident swallowed the tablet instead of it disintegrating. 3. Review of Resident #38's POS, dated December 2024, showed: - An order for Novolog Flex insulin pen 100 units per ml subcutaneous with meals per a sliding scale if blood sugar is 150-175=1 unit, 176-200=2 units, 201-225=3 units, 226-250=4 units, 251-275=5 units, 276-300=6 units, 301-325=7 units, 326-350=8 units, 351-375=9 units, 376-400=10 units, if greater than 400, call nurse practitioner (NP)/physician's assistant (PA), dated 10/16/24. Observation of Resident #38's medication administration on 12/04/24 at 11:23 A.M., showed: - RN J administered 9 units of Novolog subcutaneously per order of the sliding scale for a blood sugar of 249 with the resident's Novolog Flex pen; - RN J failed to prime the Novolog Flex Pen per the manufacturer's instructions prior to the administration to the resident. During an interview on 12/04/24 at 11:45 A.M., RN J said he/she thought the insulin pens only needed to be primed when the pen was new, not for each insulin administration. During an interview on 12/06/24 at 9:30 A.M., the Director of Nursing (DON) said staff should prime insulin pens with two units of insulin with every insulin administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265614	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview Nursing Center	430 Salcedo Road Sikeston, MO 63801

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/24 at 10:55 A.M., the Quality Assurance (QA) Nurse said the facility followed the insulin manufacturer's recommendations.

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	265614	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearview Nursing Center	430 Salcedo Road Sikeston, MO 63801

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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 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, the facility failed to implement Enhanced Barrier Precautions (EBP) during wound care for one resident (Resident #6) out of one sampled resident. The facility failed to use proper hand hygiene during blood sugar testing for four residents (Residents #3, #10, #20 and #38) out of four sampled residents. This deficient practice had the potential to affect all residents in the facility. The facility census was 59. Review of the facility's policy, titled, Enhanced Barrier Precautions to Infection Control Guidelines, updated 2024, showed: -To prevent broader transmissions of multi-drug resistance organisms (MDROs) and to help protect patients with chronic wounds and indwelling devices. EBP should be implemented for the period of their stay or until wounds have resolved or indwelling medical devices have been removed; - Examples of MDROs include, but are not limited to, methicillin-resistant staphylococcus aureas (MRSA), vancomycin-resistant enterococci (VRE), extended spectrum beta-lactamase (ESBL-producing enterobacterais) and drug-resistant streptococcus pneumoniae; - Who requires EBP, residents known to be infected or colonized with a MDRO, residents with an indwelling medical device, and residents with a wound, regardless of their MDRO status; - When to use EBP, during high-contact resident care activities, such as, performing wound care; - Gown and gloves are required when conducting high-contact resident care activities, such as wound care. Review of the facility's policy titled, Diabetic Infection Control, undated, showed: - Gloves are to be worn when performing finger sticks and changed between resident contacts; - Remove and discard gloves in appropriate receptacles after each procedure that involves potential exposure to blood or body fluids, including finger stick blood sampling; - Perform hand hygiene (i.e., hand washing with soap and water or use an alcohol-based hand rub) immediately after removal of gloves and before touching other medical supplies intended for use on another resident. 1. Observation on 12/05/24 at 1:28 P.M., of Resident #6's wound care showed: - No EBP signage posted outside of the resident's room; - Registered Nurse (RN) J did not put on isolation gown, did not perform hand hygiene, put on gloves, and entered the resident's room; - RN J removed the saturated dressing from the resident's left neck area; - RN J performed hand hygiene and changed gloves; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- RN J used wound cleanser and gauze to clean the wound, did not perform hand hygiene, did not change gloves, and patted the wound dry with clean gauze; - RN J performed hand hygiene and put on clean gloves; - RN J applied a 2x2 gauze dressing and secured with medical tape; - RN J took the biohazard bag outside of the resident room and disposed of the bag in the trash can attached to the treatment cart; - RN J removed the gloves and did not perform hand hygiene. During an interview on 12/03/24 at 10:01 A.M., Resident #6 said he/she didn't know why they had a dressing applied to his/her neck. 2. Observation on 12/04/24 at 11:10 A.M., of Resident #10's blood sugar testing showed: - RN J did not perform hand hygiene and put on gloves; - RN J performed the resident's blood sugar testing; - RN J removed the gloves and did not perform hand hygiene. 3. Observation on 12/04/24 at 11:16 A.M., of Resident #20's blood sugar testing showed: - RN J did not perform hand hygiene and put on gloves; - RN J performed the resident's blood sugar testing; - RN J removed the gloves and did not perform hand hygiene. 4. Observation on 12/04/24 at 11:23 A.M., of Resident #38's blood sugar testing showed: - RN J did not perform hand hygiene and put on gloves; - RN J performed the resident's blood sugar testing; - RN J removed the gloves and did not perform hand hygiene. 5. Observation on 12/04/24 at 11:26 A.M., of Resident #3's blood sugar testing showed: - RN J did not perform hand hygiene and put on gloves; - RN J performed the resident's blood sugar testing; - RN J removed the gloves and did not perform hand hygiene. (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 12/06/24 at 9:30 AM, the Director of Nursing (DON) said Resident #6 should have been on EBP. With EBP, staff should be putting on a gown and gloves and removing the gown and gloves within the resident's room. She said nurses should be performing hand hygiene prior to putting on gloves and after removing gloves for any procedure, including blood sugar testing.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service and failed to provide the required annual competencies of Dementia Care (care of a resident with an impaired ability to remember, think, or make decisions) for two certified nurse assistants (CNA) (CNA A and CNA B) of two nurse aides sampled. The facility census was 59. The facility did not provide a nurse aide in-service policy. Review of the facility assessment, revised 02/06/24, showed: - Required in-service training for nurse's aides: 1. Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; 2. Include dementia management training and resident abuse preventions training; 3. Address areas of weakness as determined by the facility assessment and address the special needs of residents to as determined by the facility staff; 4. For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. 1. Review of the facility's August 2023 - July 2024 in-service records showed: - CNA A's hire date of 08/13/22; - CNA A attended a total of seven monthly in-services; - No time duration documented on the monthly in-service sheets; - CNA A did not attend an annual competency in-service on Dementia Care. 2. Review of the facility's November 2023 - October 2024 in-service records showed: - CNA B's hire date of 11/02/21; - CNA B attended a total of six monthly in-services; - No time duration documented on the monthly in-service sheets; - CNA B did not attend an annual competency in-service on Dementia Care. During an interview on 12/06/24 at 10:50 A.M., the Director of Nursing (DON) said nurse aid education training should include Dementia Care. Nurse-aides should receive 12 hours of education training to meet the annual in-service requirement. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/06/24 at 10:56 A.M., the Administrator said nurse aid education training should include Dementia Care. Nurse-aides should receive 12 hours of education training to meet the annual in-service requirement.