STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265577	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marshfield Care Center for Rehab and Healthcare	800 South White Oak Marshfield, MO 65706

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34871 Based on interview and record review, the facility failed to ensure all resident's drug regimens were free from unnecessary drugs when staff failed to provide adequate monitoring related to the administration of one resident's (Resident #148) diltiazem (used to treat high blood pressure and to control angina (chest pain) for (bradycardia-type of abnormal heart rhythm that occurs when the heart beats more slowly than normal) medication. A sample of 18 residents were reviewed in a facility with a census of 51. Review of the facility's policy titled Administering Medications, revised December 2012, showed the following: -Medications shall be administered in a safe and timely manner, and as prescribed; -Medications must be administered in accordance with the orders, including any required time frame. Review of the drug information insert for diltiazem, dated 08/02/24, showed dilitiazem hydrochloride (HCL) decreases blood pressure. Dilitiazem hydrochloride therapy and may result in symptomatic hypotension (low blood pressure). 1. Review of Resident #'148's face sheet (admission data) showed the following: -admitted [DATE]; -Diagnoses include cognitive communication deficit, bradycardia, and Parkinson's disease. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 07/19/24, showed resident had severely impaired cognitive skills. Review of the resident's care plan, initiated on 07/31/24, showed the following: -At risk for adverse reactions of his/her medications. The resident received a variety of medications which may lead to adverse reactions; -Staff should administer the resident's medications as ordered; (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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident has altered cardiovascular (relating to the heart and blood vessels) status related to bradycardia and paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Review of the resident's July 2024 Physician Orders Sheet (POS) showed the following: -An order, dated 07/17/24 , for diltiazem HCL oral tablet, 30 milligrams (mg), give one tablet by mouth (PO) three times (TID) a day related to bradycardia. Hold if systolic blood pressure reading (measured when the heart beats, when blood pressure is at its highest) is less than 110 millimeters of mercury (mmHg.) Review of the resident's July 2024 Medication Administration Record (MAR) showed the following: -An order, dated 07/17/24 , for diltiazem HCL oral tablet, 30 mg, give one tablet PO TID related to bradycardia. Hold if systolic blood pressure reading is less than 110 mmHg; -On 07/24/24, Certified Medication Technician (CMT) G documented the resident's blood pressure as 107/73 mmHg. CMT G documented administration of the diltiazem HCL. (The blood pressure was not within parameters to administer per the physician order.); -On 07/28/24, CMT G documented the resident's blood pressure as 106/90 mmHg. CMT G documented administration of the diltiazem HCL. (The blood pressure was not within parameters to administer per the physician order.); -On 07/30/24, CMT G documented the resident's blood pressure as 98/48 mmHg. CMT G documented administration of the diltiazem HCL. (The blood pressure was not within parameters to administer per the physician order.) During an interview on 08/01/24, at 10:14 A.M., Licensed Practical Nurse (LPN) I said the following: -Staff should find the medication, ensure the correct resident, check the medication and time, and administer as ordered; -Staff should document administration of a medication in the computer system; -The diltiazem medication parameters was to hold the medication if the resident's systolic blood pressure is not within the parameters; -The order was to hold the diltiazem if the systolic blood pressure is less than 110 mmHg; -Staff should not give the medication if the resident's systolic blood pressure was below 110 mmHg; -The physician ordered to hold the Diltiazem if below 110 mmHg due to it could drop the resident's blood pressure more. During an interview on 08/01/24, at approximately 10:30 A.M., CMT G said the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff should read the physician order before administering a medication; -Staff should read the directions if a medication order has specific parameters; -The resident's diltiazem order was to hold it if the systolic blood pressure is less than 110 mmHg; -He/she should not have given the medication with the blood pressure was out of parameters. During an interview on 08/01/24, at 11:23 A.M., the Director of Nursing (DON) said the following: -Staff should check a resident's blood pressure if the directions include parameters; -Staff should document the blood pressure; -The order was to hold the diltiazem if the systolic is less than 110 mmHg; -Reasons for the parameters for diltiazem was due to the resident's blood pressure could drop even more; -She expected staff to follow the physician orders; -Staff should not have administered diltiazem on the dates the resident's blood pressure was out of parameters. During an interview on 08/01/24, at 11:23 A.M., the Administrator said she expected nursing staff to follow physician orders and ordered parameters for the resident's diltiazem.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48187 Based on observation, record review, and interview, the facility staff failed to ensure all residents were free from significant medication errors when staff failed to prime (removing the air from the needle and cartridge that may collect during giving the resident too much or too little insulin) an insulin pen for one resident (Resident #30) prior to the administration of insulin. The facility had a census of 51. Review of the facility's policy titled Insulin Administration, revised September 2014, showed the policy did not address priming insulin pens before injection. Review of the facility's policy titled Administering Medications, revised December 2012 showed the policy did not address priming insulin pens before injection. Review of the manufacturer's insert regarding NovoLog (rapid acting insulin) Flex pens, last revised on March 2008, showed the pen should be primed before each injection. The pen should be primed by the following steps: -Turn the dose selector to select two units; -Hold the pen with the needle pointing up; -Tap the cartridge gently with finger a few times to make any air bubbles collect at the top of the cartridge; -Keep the needle pointing upwards and press the push-button all the way in. The dose selector returns to zero; -A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times; -If a drop of insulin is not seen after six times, do not use the pen. 1. Review of Resident #30's face sheet (brief resident profile sheet) showed the following information: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a group of lung diseases making it difficult to breathe), high blood pressure, peripheral vascular disease (circulation disease caused by narrowed blood vessels), and diabetes. Review of the resident's care plan, revised 06/01/24, showed the following information: -At risk for decrease in nutritional needs related to his/her diabetes; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff to perform accu-checks (blood glucose test) as ordered by the physician; -Administer medications for diabetes as ordered by the physician. Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 06/27/24, showed the resident was cognitively intact. Review of the resident's physician order sheet (POS), current as of 08/01/24, showed the following orders: -An order, dated 06/12/24, to check blood glucose (sugar) before meals and at bedtime; -An order, dated 07/15/24, for Novolog U-100 Insulin aspart solution 100 unit/ml (unit of fluid volume), 4 units with meals subcutaneously (inject under the skin). Staff to hold if blood sugar glucose is less than 100 milligrams (mg)/deciliter (dL). Administer with meals, three times a day. Observation on 07/30/24, at 03:47 P.M., showed Licensed Practical Nurse (LPN) J went to the resident's room and checked the resident's blood sugar. The resident's blood sugar level measured 305 mg/dL. The LPN applied a new needle to the insulin pen. The LPN washed his/her hands, donned gloves, cleansed the resident's abdomen with an alcohol wipe, then administered the insulin to the resident's abdomen. The LPN pushed the knob, administered the dose, and held the pen in place for 5 seconds. The LPN did not prime the pen prior to administration of the insulin. During an interview on 07/30/24, at 3:55 P.M., LPN J said that he/she does not prime the pen prior to administering insulin. LPN J said that these pens come pre-dosed and pre-primed and are ready to go. Priming is not needed and that he/she never primes any of the pens. During an interview on 07/31/24, at 11:32 A.M., LPN I said that he/she always primes insulin pens with two units of insulin, prior to administering the insulin. LPN I said that all the nurses should know to prime the pen before each use. During an interview on 08/01/24, at 9:57 A.M., the Director of Nursing (DON) said that he/she was responsible for training the nursing staff how to properly administer insulin. He/she teaches the staff to complete hand hygiene, apply a new needle, prime with two units of insulin, cleanse the skin with an alcohol wipe, administer the insulin and then hold in place for 10 seconds. The DON said that the education is provided to nurses on hire and yearly. Staff should always prime all insulin pens with two units of insulin before each use. He/she expected all nursing staff to prime the pen every time. During an interview on 08/01/24, at 10:00 A.M., the Administrator said that he/she expected staff to administer insulin per physician orders and as they have been trained.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45176 Based on observation, interview, and record review, the facility failed to maintain an effective pest control program to control the gnat population, when multiple gnats were present in one room, with two residents (Residents #2 and Resident #37) out of a total sample of 18. The facility census was 51. Review of the facility policy titled Pest Control, revised May 2008, showed the following: -The facility shall maintain an effective pest control program; -This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. 1. Review of Resident #2's face sheet (admission data) showed the resident admitted to the facility on [DATE]. Review of the resident's annual assessment sheet (MDS - a federally-mandated assessment form completed by facility staff), dated 06/03/24, showed the following: -No cognitive impairment; -Resident required set up with personal hygiene. 2. Review of Resident #37's face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Severe cognitive impairment; -Set up or supervision with daily living skills. 3. Observation and interview on 07/29/24, at 4:40 P.M., in Resident #2 and #37's room, showed the following: -Resident #2 said Resident #37 leaves food and cups in the room that caused the room to have gnats; -Resident #2 said he/she had asked his/her son to bring some fly traps; -Two cups and a bowl with some type of food sat by the sink; -Four gnats flew around the sink, two gnats sat on the cups, and at least four gnats sat on the ceiling above the sink. Observation on 07/30/24, at 9:49 A.M., of Resident #2 and #37's room, showed the following: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Four gnats flew around the sink; -One partially eaten banana lay on Resident #37's bedside table and five gnats flew on and around the banana. Observation on 07/31/24, at 8:32 A.M., of Resident #2 and #37's room, showed the following: -Resident #37 came into his/her room to lay down; -Several gnats flew around the sink. There was an almost empty cup of chocolate milk that had four gnats on and around the cup. Observation on 07/31/24, at 2:18 P.M. and 4:39 P.M., of Resident #2 and #37's room, showed the following: -Food in the sink and two cups that had some milk in them; -Three flies flew around the sink. Several gnats flew around or on the ceiling and gnats sat on the cups; -Resident #37 had several cups on his/her bedside table. there were three gnats flying around the table. Observation on 08/01/24, at 8:20 A.M., of Resident #2 and #37's room, showed the following: -Resident #37 lay in his/her bed with his/her eyes closed; -Three large cups on the bedside table and two packs of opened candy sat on the resident's bed; -Several gnats and flies flew around the table and bed. Observations in on 08/01/24, at 10:56 A.M., 1:11 P.M., and 2:05 P.M., of Resident #2 and #37's room, showed the Maintenance Director in the resident's room tested the resident's water temperature while several gnats flew around the resident's sink and the ceiling above the sink. During an interview on 08/01/24, at 9:15 A.M., Certified Nurse Aide (CNA) E said the following: -He/she had seen gnats, usually around the resident's sink, but they're usually gone the next day; -He/she has seen them in Resident #37's room; -Resident #37 hoards food and cups in his/her room; -He/she tried to pick up the food and cups at least one time per shift; -He/she reported seeing the gnats in resident's room to the Maintenance Director. During an interview on 08/01/24, at 9:30 A.M., Housekeeper A, said the following: (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she had seen the gnats in residents' rooms, especially in Resident #37's room around his/her sink; -Resident #37 likes to keep a lot of food and drinks in his/her room and sometimes he/she finds half eaten bananas; -He/she has told the Maintenance Director about the gnats in Resident #37's room; -A pest company sprays, but he/she doesn't know how often. During an interview on 08/01/24, at 10:20 A.M., Certified Medication Technician (CMT) G, said the following: -He/she has seen gnats in a few of the residents' rooms; -He/she sees some in Resident #37's room; -Housekeeping usually takes care of them and there is a pest control company that sprays; -Staff usually pick up any cups and dishes not being used in resident rooms routinely. During an interview on 08/01/24, at 10:30 A.M., Registered Nurse (RN) H, said the following: -There have been complaints from residents about gnats; -The residents have been complaining less because housekeeping has been cleaning specific rooms; -Resident #37 likes to keep fruit in his/ her room; -Staff have been trying to make sure things are picked up in the resident's rooms and they've been spraying. They also have a pest control company; -He/she would tell the Maintenance Director if there was issues with gnats. During an interview on 08/01/24, at 10:40 A.M., the Maintenance Director said the following: -He/she didn't know there was an issue with gnats until last week; -He/she was told there were gnats on C hall so the facility bought some plug in devices to put in a few rooms; -He/she has seen some in Resident #37's room, but since putting the electronic devices in some other rooms it has drastically reduced the gnats; -He/she believed the source was due to some bananas that he/she threw way back behind the facility and this pulled the gnats to the facility doors; -He/she has not found any cups of bowls of food in residents' rooms; (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she has seen food be put down sinks and he/she has needed to clean out the drains; -He/she has told housekeeping staff to run the sinks for five minutes when they're in the rooms cleaning. Observation and interview on 08/01/24, at 12:17 P.M., in Resident #2 and #37's room, with the Administrator, showed the following: -Multiple gnats flew on Resident #37's bedside table and the resident's cup on the bedside table; -Multiple gnats sat on the ceiling and wall beside the sink area in the resident's room; -Multiple gnats buzzed around and sat on the three cups beside the resident's sink; -The Administrator said she was not aware of the gnats in the resident's room; -Staff should tidy up the resident's room and take out any cups or food; -Staff should notify administration staff of the gnats in the resident's room; -The facility has placed some plug in devices in other resident rooms around the room. During an interview on 08/01/24, at 3:06 P.M., the Administrator said the following: -She expected staff to report to the maintenance or administrative staff when there are gnats; -She was not aware of the gnats in the resident's room and facility staff were focused on other rooms on the same hall which had gnats. MO00237455 34871