STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26E256	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JOHNSON COUNTY CARE CENTER	122 EAST MARKET STREET WARRENSBURG, MO 64093

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a Care Plan for weight loss/nutrition for two sampled residents (Resident #14 and #53) out of 16 sampled residents. The facility census was 64 residents. Record review of the facility's policy for care plan dated 2014 showed: -The charge nurses and the Director of Nursing (DON) shall communicate to each other the care delivery and the progress of care and other provider's plan of care. -Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning) coordinator follows the Resident Assessment Instrument (RAI - helps facility staff to gather definitive information on a resident which must be addressed in an individualized care plan) to develop the care plan and coordinates the RAI process. -The MDS coordinator communicates with the care staff, licensed and non-licensed personnel and reviews the medical records in order to obtain the information for developing the care plan. -The care plans shall be developed with all interdisciplinary team input and the resident/family members. -The care plan can be reviewed and revised at any time to ensure it reflects the resident's current conditions. -The care plan will be reviewed and updated every three months during care plan meetings with input from all care plan team members. -The charge nurses will update the care plan immediately when there are falls, behaviors, change in functional ability. -The charge nurse will then notify the MDS coordinator who will put changes in the care plan system and reprint the care plan on the next working day. 1. Record review of Resident #14's admission record showed he/she was admitted on [DATE] with the following Diagnoses: [REDACTED]. -Chronic (persisting for a long time or constantly recurring) [MEDICAL CONDITION] (relating to [MEDICAL CONDITIONS] (a type of virus causing liver inflammation and long-term or chronic infections). -[MEDICAL CONDITIONS] (a type of virus causing liver inflammation and long-term or chronic infections). Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Required set up only from staff for eating. -Had no weight loss. -Weighed 146 pounds. Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Required set up only from staff for eating. -Had no weight loss. -Weighed 148 pounds. Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Required set up only from staff for eating. -Had a 6.5% weight loss in three months. -Was not on a physician's prescribed weight loss regimen. -Weighed 139 pounds. Record review of the resident's food intake record dated December 2019 showed: -Breakfast, lunch, and dinner meals were only charted for ten out of 31 days. -None of the uncharted days showed that the resident refused the meals. -The 10 days charted showed an average meal consumption of 75%-100%. -The resident did drink Ensure (brand of nutrition shake that provides complete balanced nutrition to help gain or maintain weight) nutritional shakes and was documented with the meal fluid intake. Record review of the resident's food intake record dated January 2020 showed: -Breakfast, lunch, and dinner meals were charted as refused or not charted 20 out of 31 days. -The eleven days charted showed an average meal consumption of 25%-80%. -The resident did drink Ensure nutritional shakes and was documented with the meal fluid intake. Record review of the resident's food intake record dated February 2020 showed: -Breakfast, lunch, and dinner meals were charted as refused or not charted 15 out of 29 days. -The 14 days charted showed an average meal consumption of 80%-100%. -The resident did drink Ensure nutritional shakes and was documented with the meal fluid intake. Record review of the resident's food intake record dated March 2020 showed: -Breakfast, lunch, and dinner meals was not charted on the first day out of 5 days. -The 5 days charted showed an average meal consumption of 80%-100%. -The resident did drink Ensure nutritional shakes and was documented with the meal fluid intake Record review of the resident's care plans showed there was no care plan that addressed his/her nutritional status or weight loss. During an interview on 3/2/20 at 2:18 P.M., the resident said he/she: -Had lost some weight. -Did skip/refuse meals. -Sometimes was too tired to go eat or just didn't feel like eating, even when the staff try to get him/her to eat. -Poured the Ensure drink into his/her coffee. It made the coffee taste better. -Liked peanut butter and jelly sandwiches and liked to dip them into his/her coffee. -Sometimes would just request a peanut butter and jelly sandwich. -Ate all of his/her lunch today. During an interview on 3/4/20 Certified Medication Technician (CMT) B said: -When the resident skipped a meal he/she would offer the resident a snack when he/she was up. -The resident usually ate the snack and would drink the Ensure shake. Record review of the Registered Dietician's (RD) nutritional progress record dated 3/5/20 showed: -The resident said he/she often slept through breakfast, lunch, and dinner. -He/she drank strawberry Ensure/health shakes with meals. -He/she agreed to increasing the strawberry supplements to five times a day. -Would recommend to increase the strawberry supplements to TID with snacks and with lunch and dinner. -The resident received Thera tabs and multi vitamins daily. 2. Record review of resident #53's admission record showed he/she was admitted on [DATE] with the following Diagnoses: [REDACTED]. -Protein malnutrition (insufficient intake of protein) -Diabetes Mellitus II (condition that affects the way the body processes blood sugar (glucose)). Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Required set up and supervision from one staff member for eating. -Had a [DIAGNOSES REDACTED]. -Had no weight loss. -Weighed 153 pounds. Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Required set up and supervision from one staff member for eating. -Had a [DIAGNOSES REDACTED]. -Weighed 154 pounds. Record review of the resident's annual MDS dated [DATE] showed he/she: -Required set up and supervision from one staff member from eating. -Had a [DIAGNOSES REDACTED]. -Weighed 148 pounds. Record review of the resident's care plans showed there was no care plan that addressed his/her nutritional status or potential for weight loss due to his/her [DIAGNOSES REDACTED]. During an interview on 3/6/20 at 8:55 A.M., the MDS Coordinator said: -Resident's who have had weight loss should have a care plan that addresses weight loss. -Resident's who have a potential for weight loss, who refuse to eat all meals, or have nutritional diagnoses, including malnutrition, should have a care plan that addresses potential for weight loss and/or his/her nutritional status. During an interview on 3/6/20 at 2:33 P.M., the Director of Nursing (DON) said: -There should be a care plan for weight loss and/or nutrition when a resident is not eating well, has weight loss, or [DIAGNOSES REDACTED]. -The resident's physician should be notified if there were recommendations from the RD.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one sampled resident (Resident #39) received his/her medication as ordered; to document the reasons medications were not administered as ordered for one sampled resident (Resident #39); to indicate the [DIAGNOSES REDACTED].#39, #64, #26 and #25); and to ensure the physician had ordered blood sugar samples for one sampled resident (Resident #46) out of 16 sampled residents. The facility census was 64 residents. Record review of the facility's physician's orders [REDACTED]. -Inform the pharmacy if the physician is not responding to pharmacy requests and ask the pharmacy to contact the physician. -Continue to call the physician for the pharmacy inquiry. -Circle initials on the Medication Administration Record [REDACTED]. 1. Record review of Resident #39's care plan dated 10/2[DATE]9 showed he/she experienced pain, received antidepressant medication and received antianxiety medication. Record

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

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.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated [DATE] showed the following staff assessment of the resident: -Was cognitively intact. -Had [DIAGNOSES REDACTED]. -Received scheduled pain medication. -Reported he/she had frequent pain with an eight out of ten on a pain scale with ten being the worst pain. -Received antianxiety medication and antidepressant medication seven out of the past seven days. Record review of the resident's Nurse Practitioner's (NP) note dated 2/19/20 showed: -The resident reported he/she was trying to keep his/her anxiety under control. -The resident reported being anxious. -The resident's [MED] (anticonvulsant medication that is also used to treat anxiety by calming the brain and nerves) would be increased to 0.5 milligrams (mg) three times daily to manage anxiety. Record review of the resident's February 2020 Medication Administration Record [REDACTED]. -Initials were circled three times daily on 2/28/20 and 2/29/20 as [MED] 0.5 mg not being administered. -It was documented on the back of the MAR indicated [REDACTED].M. because it was unavailable. -There was no reason documented as to why the resident did not receive his/her [MED] 0.5 mg the other five times in February 2020. -A physician's orders [REDACTED]. -Initials were circled as not being administered 22 times from 2/22/20-2/29/20. -It was documented on the back of the MAR indicated [REDACTED]. -There were no reasons documented as to why the resident did not receive his/her [MEDICATION NAME] 600 mg the other 20 times in February 2020. During an interview on 3/2/20 at 9:45 A.M., the resident said: -The facility was out of some of his/her medication for multiple days. -He/she thought the medications he/she was not receiving were [MED] and an antidepressant. -His/her anxiety is going through the roof because of not receiving his/her [MED]. Record review of the resident's March 2020 MAR indicated [REDACTED].M. showed: -A physician's orders [REDACTED]. -The resident did not receive his/her [MED] 0.5 mg eight out of eight opportunities [DATE]-3/3/20 at noon. -It was documented on the back of the MAR indicated [REDACTED]. -There were no reasons documented as to why the resident did not receive his/her [MED] 0.5 mg the other six times in March 2020. Record review of the resident's nurses' notes for February 2020 and March 2020 showed no documentation regarding the resident's [MED] or [MEDICATION NAME]. During an interview on 3/3/20 at 11:08 A.M., Licensed Practical Nurse (LPN) C said: -They were out of the resident's [MED]. -The pharmacy contacted the physician and they are waiting for a written prescription from the doctor. -There's nothing they could do about the resident not having his/her medication. -They were waiting on the doctor. During an interview on 3/6/20 at 9:40 A.M., LPN B said: -If a medication was not administered, the reason should be documented on the back of the MAR. -They were supposed to order medications before they run out. -If a medication was not available, they should call the pharmacy again, call the doctor's office again and/or try to contact the nurse practitioner. -Sometimes they ask the pharmacy to call the doctor again to request the written prescription. During an interview on 3/6/20 at 2:33 P.M., the Director of Nursing (DON) said: -Two to seven days before a resident's medication will run out, the nurse should pull the sticker off the card and send it to the pharmacy for a refill. -The pharmacy calls the doctor, the doctor has to write a prescription and send it to the pharmacy. -They should keep calling the pharmacy every day if a resident's medication has not been received. -They should call the doctor if a resident's medication has not been received. -He/she doesn't know if anyone called the resident's doctor. -The resident's doctor is the facility's medical director. -They should document why a medication was not administered on the back of the MAR. Record review of the resident's March 2020 physician's orders [REDACTED]. -Some of the resident's [DIAGNOSES REDACTED]. 2. Record review of Resident #64's March 2020 POS showed: -A physician's orders [REDACTED]. -The resident had a [DIAGNOSES REDACTED]. 3. Record review of Resident' #26's March 2020 POS showed: -A physician's orders [REDACTED]. -The resident had a [DIAGNOSES REDACTED]. 4. Record review of Resident #25's March 2020 POS showed: -A physician's orders [REDACTED]. -The resident has a [DIAGNOSES REDACTED]. 5. During an interview on 3/6/20 at 2:33 P.M., the DON said: -There should be [DIAGNOSES REDACTED]. -The charge nurse was responsible for ensuring there was a [DIAGNOSES REDACTED]. 6. Record review of Resident #46's face sheet showed he/she was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Record review of the resident's care plan dated 1/29/20 showed: -The resident had nutritional problems related to Diabetes. -The staff was to obtain laboratory work as ordered. -The staff was to obtain diagnostic work as ordered. -The staff was to report the results to the physician. Record review of the resident's January 2020 POS showed: -The resident did not have a physician's orders [REDACTED]. -The January POS was signed by the physician on 1/7/20. Record review of the resident's February 2020 POS showed: -The resident did not have a physician's orders [REDACTED]. -The February POS was signed by the physician on 2/4/20. Record review of the resident's March 2020 POS showed: -The resident did not have a physician's orders [REDACTED]. -The March POS was signed by the physician on 3/3/20. Record review of the resident's MAR indicated [REDACTED]. -There was no order to check blood sugars. During an interview on 3/5/20 at 6:00 A.M. Certified Medication Technician (CMT) A said: -The nurses get the resident's blood sugars. -The nurses were responsible for verifying that the orders are correct. During an interview on 3/5/20 at 6:24 A.M. LPN A said: -The DON would check the orders on the POS to make sure they were correct. -There should have been an order for [REDACTED]. -There was no order from the Physician to check the resident's blood sugars. During an interview on 3/6/20 at 2:32 P.M. the DON said: -There should have been an order for [REDACTED]. -The MDS coordinator double checks the orders.

F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide or obtain physician ordered medical services to meet the residents' needs by not ensuring tests that were ordered by a physician were done for three sampled residents (Resident #36, Resident #46, and Resident #57) out of 16 sampled residents. The facility census was 64 residents. 1. Record review of Resident #36's face sheet showed he/she was re-admitted on [DATE] with the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION] ([MEDICAL CONDITION] - an [MEDICAL CONDITION] lung disease that causes obstructed airflow from the lungs). -Dyspnea (a shortness of breath related to heart or lung disease). -Obstructive sleep apnea (a disorder in which breathing starts and stops repeatedly during sleep). -High blood pressure. -Metabolic [MEDICAL CONDITION] (when your immune systems attacks your brain and changes the way it works). -[MEDICAL CONDITION] (when the [MEDICAL CONDITION] does not produce enough hormone). -Heart failure (when the heart muscle does not pump blood as it should). -Pulmonary fibrosis (when lung tissue becomes damaged or scarred). -[MEDICAL CONDITION] (a condition in which you lack enough healthy red blood cells to carry [MED]gen to the body's tissues). -[MEDICAL CONDITION] (an irregular heart rhythm). -Diabetes (a group of diseases that affect how your body uses blood sugar). -The resident was not his/her own person. Record review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated [DATE] showed he/she: - Was mildly cognitively impaired with a BI[CONDITION] (brief interview for mental status) of 11 out of 15. -Was independent with activities of daily living. -Had [MEDICAL CONDITION]. -Had [MEDICAL CONDITION] Fibrillation. -Had Diabetes. -Had a [MEDICAL CONDITION] disorder. -Had [MEDICAL CONDITION]. -Had [MEDICAL CONDITION]. Record review of the resident's care plan dated [DATE] showed: -The staff was to follow the physician's orders [REDACTED]. -The staff was to ensure labs were done as ordered by the physician related to the resident's high blood pressure. -The staff was to ensure Fasting Serum Blood Sugars were done as ordered by the physician related to the resident's Diabetes. Record review of the resident's January 2020 physician's orders [REDACTED].'s orders [REDACTED]. -No documentation the resident's EKG ordered to be completed in February 2020 was completed as ordered. 2. Record review of Resident #46's face sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION] (elevated levels of lipids in the bloodstream). -[MEDICAL CONDITION]. -[DIAGNOSES REDACTED] (a low level of potassium in the blood which can an abnormal heart rhythm). -The resident had a guardian. Record review of the resident's Annual MDS dated [DATE] showed he/she: -Was cognitively intact with a BI[CONDITION] of 15 out of 15. -Had Diabetes. -Had [MEDICAL CONDITION]. -Had [MEDICAL CONDITION]. -Had behaviors. -Would reject bloodwork. Record review of the resident's care plan dated 1/29/20 showed: -The resident had nutritional problems related to diabetes. -The staff was to obtain laboratory work as ordered. -The staff was to obtain diagnostic work as ordered. -The staff was to report the results to the physician. Record review of the resident's February 2020 POS showed: -The resident had an order to have an annual EKG done in February. -The order was signed by the physician on 2/4/20. Record review of the resident's March 2020 POS showed: -The resident had an order to have an annual EKG done in February. -The order was signed by the physician on 3/3/20. Record review of the resident's medical record showed no documentation the resident's EKG ordered to be completed in February 2020 was completed as ordered. 3. Record review of Resident #57's face sheet showed he/she was admitted to the facility on [DATE] with the

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) following Diagnoses: [REDACTED]. -Vitamin D deficiency. -[MEDICAL CONDITION]. -The resident had a guardian. Record review of the resident's Annual MDS dated [DATE] showed he/she: -Was cognitively intact with a BI[CONDITION] of 12 out of 15. -Had [MEDICAL CONDITION]. -Had [MEDICAL CONDITION]'s disease. Record review of the resident's care plan dated [DATE] showed: -The staff was to follow the physician's orders [REDACTED]. -The staff was to obtain diagnostic work as ordered. -The staff was to report results to the physician. Record review of the February 2020 POS showed: -The resident had an or for an annual EKG to be done in February. -The order was signed on 2/4/20. Record review of the March 2020 POS showed: -The resident had an or for an annual EKG to be done in February. -The order was signed on 3/8/20. Record review of the resident's medical record showed no documentation the resident's EKG ordered to be completed in February 2020 was completed as ordered. 4. During an interview on 3/5/20 at 6:00 A.M. Certified Medication Technician (CMT) A said: -The nurses were responsible for verifying that the orders were correct. -The nurses were responsible to ensure physician's orders [REDACTED].M. Licensed Practical Nurse (LPN) A said: -The Director of Nursing (DON) would check the orders on the POS to make sure they were correct. -The DON would check the orders on the POS to make sure they were done. During an interview on 3/6/20 at 2:32 P.M. the DON said: -The charge nurse double checks the orders. -The MDS Coordinator double checks the orders. -He/she would expect the staff to ensure tests have been done. -The charge nurse was responsible to ensure orders were transcribed and completed as ordered. -They have not been consistently done. -They were trying to get them caught up on incomplete orders.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure full, metal bar side rails were protected to reduce the risk of injury for one sampled resident (Resident #30) who had a [MEDICAL CONDITION] disorder out of 16 sampled residents. The facility census was 64 residents. 1. Record review of Resident #30's care plan revised 11/2/19 showed: -The resident was witnessed falling and/or was found on the floor. -The resident used bed rail restraints due to a [MEDICAL CONDITION] disorder. Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated 1/3/20 showed the following assessment of the resident: -Had short-term and long-term memory impairment. -Was dependent upon staff for bed mobility. -Had a [DIAGNOSES REDACTED]. -Used bed rail restraints daily. Record review of the resident's March 2020 physician's orders [REDACTED]. Observations showed: -During initial tour beginning on 3/2/20 at 9:30 A.M., the resident was in bed asleep with full metal bar bed rails with no padding, up on both sides of the bed. -On 3/5/20 at 6:06 A.M., the resident was in bed asleep with full metal bar bed rails with no padding, up on both sides of the bed. -On 3/5/20 at 10:15 A.M., the resident was in bed asleep with full metal bar bed rails with no padding, up on both sides of the bed. During an interview on 3/6/20 at 2:33 P.M., the Director of Nursing (DON) said: -The resident hasn't had any [MEDICAL CONDITION] recently. -He/she didn't think about the metal bed rails being a safety risk with the resident's [MEDICAL CONDITION] disorder diagnosis.
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on observation, interview and record review, the facility failed to post the daily census and the total hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift including Registered Nurses (RN's), Licensed Practical Nurses (LPN's), Certified Medication Technicians (CMT's) Certified Nurse Assistants (CNA's), and Nurse Assistants (NA's). The facility census was 64 residents. The facility did not have a policy regarding posting census or nursing staff hours worked per shift. 1. Observation on 3/2/20 to 3/6/20 showed: -The total hours worked per discipline was not posted daily. -The staff schedule was posted but it did not contain the total hours per discipline worked or the daily resident census. Record review of the daily staffing sheets dated 2/23/20 to 3/7/20 showed: -The names of the licensed and unlicensed nursing staff directly responsible for resident care per shift. -Did not include the total number of hours worked by each position listed per shift. -No daily resident census for the facility on the staffing sheets. 2. During an interview on 3/6/20 at 2:33 P.M., the Director of Nursing (DON) said: -The secretary was responsible for posting the staffing sheet in the main lobby. -The charge nurse from the previous shift on the second floor was responsible for posting the staffing sheets on the second and third floors. -The actual total hours of each position directly responsible for resident care per shift should be noted on each daily staffing sheet. -The facility daily census should be on each daily staffing sheet. -He/She will start putting the daily census and the actual total hours of each position directly responsible for resident care on the daily staffing sheets.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** Based on interview and record review, the facility failed to ensure the controlled medications (narcotics - medications with a potential for abusive use and dependence upon the medication) were counted and documented at the beginning and the end of the 10:00 P.M. to 6:00 A.M., shift on the second floor to ensure the accuracy of the distribution and use of the controlled medications. This had the potential to affect all residents who used controlled medications on the second floor. The facility census was 64 residents. Record review of the facility's undated controlled drug policy and procedure the narcotic count and inventory showed: -Controlled drugs are counted every eight hour tour by the nurse reporting on duty with the nurse reporting off duty. -The inventory of the controlled drugs must be recorded on the narcotic records and signed for correctness of count. -The controlled drug check list must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct. -If a discrepancy is found: --Check the resident's order sheets and chart to see if a narcotic has been administered and not recorded. --Check previous recordings on the control sheets for mistakes in arithmetic. --If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the supervisor. Record review of the facility's medication management and monitoring policy dated 2019 showed: -It was the responsibility of the charge nurses and the Certified Medication Technician (CMT) to ensure the correct counting of medications on the changeover (changing out the old month records for the new month's records) shift. -It was the responsibility of the nursing professional (Registered Nurse (RN), Licensed Practical Nurse (LPN) to count together each shift for the schedule II (drugs with a high potential for abuse with use potentially leading to severe psychological or physical dependence) medications to ensure the correct number of delivery and document and sign off the book. -Notify the Director of Nursing (DON) immediately for any discrepancy for investigation. 1. Record review of the narcotic count record for the 3/4/20 10:00 P.M. to 3/5/20 6:00 A.M. shift showed: -The oncoming nurse signed on 3/4/20 at 10:00 P.M. -The off going nurse did not sign on 3/5/20 at 6:00 A.M. after completing the narcotic count. -The oncoming nurse signed on 3/5/20 at 6:00 A.M. after completing the narcotic count. Record review of the narcotic count sheet dated March 2020 showed: -The 10:00 P.M. to 6:00 A.M., shifts did not have two licensed nurse's signatures. -The oncoming and off going nurse's did not sign the narcotic count sheet on [DATE], 3/2/20, and 3/3/20. During an interview on 3/5/20 at 6:05 A.M., CMT B said the nurses should sign the narcotic count record when they count coming on shift and off shift. During an interview on 3/6/20 at 2:33 P.M., the DON said: -Each nurse counting the narcotic count record signs after counting when they come on and go off shift. -He/She was responsible for checking if the narcotic count record was signed.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure diagnoses/purposes were indicated for [MEDICAL CONDITION] (any medication capable of affecting the mind, emotions, and behavior) medications on the resident's Physician order [REDACTED].#40) out of 16 sampled residents. The facility census was 64 residents. Record review of the facility's medication management and monitoring policy dated 2019 showed: -The responsibility of the Director of Nursing (DON) was to review the medication plan on a monthly basis for residents who were on [MEDICAL CONDITION] (includes antipsychotic) medications. Record review of the facility's physician's orders [REDACTED]. 1. Record review of Resident #40's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning) dated [DATE] showed: -The resident had diagnosed including: [DIAGNOSES REDACTED]. -The resident was receiving antianxiety medications (inhibits anxiety (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus) seven out of seven days in the lookback period. -The resident was receiving antidepressant medications (inhibits depression (a state of intense sadness or despair that has advanced to the point of being disruptive to an individual's social functioning and/or activities of daily living) seven out of seven days in the lookback period. -The resident was receiving hypnotic medications (drug that induces sleep) seven out of seven days in the lookback period. Record review of the resident's Significant Change MDS dated [DATE] showed he/she: -Had diagnosed including: [DIAGNOSES REDACTED]. -The resident was receiving antidepressant medications seven out of seven days in the lookback period. -The resident was receiving hypnotic medications seven out of seven days in the lookback period. Record review of the resident's POS dated February 2020 and March 2020 showed the following medications: [REDACTED]. --There was no diagnosis/purpose for use. -[MEDICATION NAME] (an antipsychotic medication used for sleep and anxiety) 7.5 mg PO. --There was no diagnosis/purpose for use. During an interview on 3/6/20 at 11:30 A.M., Certified Medication Technician (CMT) B said: -He/she had not noticed there were missing diagnoses on the MAR. -There should be a [DIAGNOSES REDACTED]. During an interview on 3/6/20 at 2:33 P.M., the DON said: -There should be a [DIAGNOSES REDACTED]. -It was the charge nurse's responsibility to see that a [DIAGNOSES REDACTED]. -The charge nurse should call the physician to receive a [DIAGNOSES REDACTED].
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide or obtain laboratory services, to meet the residents' needs by not ensuring laboratory tests that were ordered by a physician were completed and/or the resident's physician was notified of the resident's refusal for laboratory tests for two sampled residents (Resident #36 and Resident #46) out of 16 sampled residents. The facility census was 64 residents. 1. Record review of Resident #36's face sheet showed he/she was re-admitted on [DATE] with the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION] ([MEDICAL CONDITION] - an [MEDICAL CONDITION] lung disease that causes obstructed airflow from the lungs). -Dyspnea (a shortness of breath related to heart or lung disease). -Obstructive sleep apnea (a disorder in which breathing starts and stops repeatedly during sleep). -High blood pressure. -Metabolic [MEDICAL CONDITION] (when your immune systems attacks your brain and changes the way it works). -Heart failure (when the heart muscle does not pump blood as it should). -Pulmonary fibrosis (when lung tissue becomes damaged or scarred). -[MEDICAL CONDITION] (a condition in which you lack enough healthy red blood cells to carry [MED]gen to the body's tissues). -[MEDICAL CONDITION] (an irregular heart rhythm). -Diabetes (a group of diseases that affect how your body uses blood sugar). -The resident was not his/her own person. Record review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated [DATE] showed he/she: - Was mildly cognitively impaired with a BI[CONDITION] (brief interview for mental status) of 11 out of 15. -Was independent with activities of daily living. -Had [MEDICAL CONDITION]. -Had [MEDICAL CONDITION] Fibrillation. -Had Diabetes. -Had [MEDICAL CONDITION]. -Had [MEDICAL CONDITION]. Record review of the resident's care plan dated [DATE] showed: -The staff was to follow the physician's orders [REDACTED]. -The staff was to ensure labs were done as ordered by the physician related to the resident's high blood pressure. -The staff was to ensure Fasting Serum Blood Sugars were done as ordered by the physician related to the resident's Diabetes. Record review of the resident's January 2020 physician's orders [REDACTED]. -The resident's physician signed the POS on 2/4/20. Record review of the resident's March 2020 POS showed: -No documentation lab orders from January and February 2020. -No documentation lab orders were discontinued by the resident's physician. -The physician signed the POS on 3/3/20. Record review of the resident's medical record showed: -No documentation a CMP was obtained or of a CMP result from the resident's physician order [REDACTED]. -No documentation a CBC was obtained or of a CBC result from the undated resident's physician order [REDACTED]. 2. Record review of Resident #46's face sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -Paranoid [MEDICAL CONDITION]. -High cholesterol. -[MEDICAL CONDITION]. -Vitamin D deficiency (a vitamin needed for strong bones). -[DIAGNOSES REDACTED] (a low level of potassium in the blood which can an abnormal heart rhythm). The resident had a guardian. Record review of the resident's Annual MDS dated [DATE] showed he/she: -Had Diabetes. -Had [MEDICAL CONDITION]. -Had high cholesterol. -Had behaviors. -Would reject bloodwork. Record review of the resident's care plan dated 1/29/20 showed: -The resident had nutritional problems related to diabetes. -The staff was to obtain laboratory work as ordered. -The staff was to obtain diagnostic work as ordered. -The staff was to report the results to the physician. Record review of the resident's February 2020 POS showed: -The resident had an order for [REDACTED]. -The order was signed by the physician on 2/4/20. Record review of the resident's March 2020 POS showed: -The resident had an order for [REDACTED]. Record review showed the resident had refused to have labs drawn at 12:00 A.M. (midnight) on the following dates: -CMP on 10/12/19. -CMP on 11/20/19. -Valporic acid (used to treat mental illness), CBC, TSH (a test to check [MEDICAL CONDITION] level) on 1/20/19. -CMP, TSH, Valporic acid, A1C on 3/3/20. 3. During an interview on 3/5/20 at 6:00 A.M. Certified Medication Technician (CMT) A said the nurses were responsible for verifying that the orders were done. During an interview on 3/5/20 at 6:24 A.M. Licensed Practical Nurse (LPN) A said the Director of Nursing (DON) would check the orders on the POS to make sure they were completed. During an interview on 3/6/20 at 2:32 P.M. the DON said: -The charge nurse double checks the orders. -The MDS Coordinator double checks the orders. -He/she would expect the staff to ensure labs have been done. -The charge nurse was responsible. -They have not been consistently done. -They were trying to get them caught up.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview, and record review, the facility failed to follow menus prepared in advance; to have menu changes approved by the dietician or other clinically qualified nutrition professional for nutritional adequacy; to have a pre-set menu of approved alternate choices; and to ensure that the amount of prepared food was sufficient. These deficient practices potentially affected all residents who ate food from the kitchen. The facility's census was 64 residents with a licensed capacity for 87 residents. Record review of the undated Week at a Glance menus for weeks 1 through 4, provided by the Dietary Supervisor, showed the following: -Week 1 had 18 food items for various meals on various days that were crossed out completely or changed. -Week 2 had 22 food items for various meals on various days that were crossed out completely or changed. -Week 3 had 28 food items for various meals on various days that were crossed out completely or changed. -Week 4 had 29 food items for various meals on various days that were crossed out completely or changed. 1. Observations on 3/2/20 at 12:11 P.M. showed that Cook B had run out of the meatloaf for lunch and began substituting shredded turkey in its place. During an interview on 3/2/20 at 12:11 P.M., Cook B said the following: -They do not run out of food very often. -A new cook made the meatloaf today so that may be the reason they ran out. During an interview on 3/2/20 at 12:23 P.M., the Dietary Supervisor said when he/she saw how much the meatloaf had shrunk in the oven they prepared some shredded turkey as a back-up. During an interview on 3/2/20 at 1:14 P.M., the Dietary Supervisor said the following: -There was no standing alternate food menu. -If a resident wanted something besides the main meal on the menu they would offer leftovers, some kind of sandwich, or whatever was on hand. During an interview on 3/4/20 at 9:49 A.M., the Dietary Supervisor said the following: -The kitchen did not run out of food very often. -When he/she pulled the meatloaf out of the oven two days ago he/she knew it was not enough. -That incident was a fluke. -The previous Dietary Supervisor had made all the hand-written changes to the menus, but he/she was not sure why.

F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Procure food from sources approved or considered satisfactory and store, prepare,**

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	26E256	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JOHNSON COUNTY CARE CENTER	122 EAST MARKET STREET WARRENSBURG, MO 64093

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) **distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to keep the dry storage and walk-in freezer and refrigerator floors swept to avoid foodborne illness; to separate dented cans of food; to maintain sanitary food preparation equipment and utensils; to ensure plastic plate warmers and cutting boards were in good condition to avoid food safety hazards; and to adequately clean food preparation appliances. These deficient practices potentially affected all residents who ate food from the kitchen. The skilled nursing facility census was 64 residents with a licensed capacity for 87. 1. Observations during the initial kitchen inspection on 3/2/20 between 9:08 A.M. and 12:11 P.M. showed the following: -A 108 ounce (oz.) can of pork and beans dented on the bottom, a 101 oz. can of collard greens heavily dented on the side and bottom, a 104 oz. can of sliced apples dented on the side and bottom, and a 108 oz. can of applesauce dented at the top, were all on a can dispenser rack with other undented cans in the Dry Storage room. -In the next room was a three-shelf unit with 12 dented cans of various sizes on it. -Bits of plastic, paper, and cardboard were on the floor under the racks in the dry storage. -Paper, food debris, foil, and a milk carton were on the floor in the walk-in refrigerator. -Plastic and small trash were on the floor under the racks in the walk-in freezer. -A red, a brown, and a white cutting board were all heavily scored with minute bits of plastic hanging on, and the white cutting board also had brown streaks stained on it. -The green plate warmer lids and bottoms were discolored and/or chipping. -There was a large chunk of food and paper residue on the manual can opener. -A metal ladle hanging by the herbs and spices had white food residue on the rim. -The toaster had excessive crumbs in the bottom and underneath. -The resident microwave in the dining room adjoining the kitchen had food splatters on the inside top, bottom, door, and sides. 2. Observations during the follow-up kitchen inspection on 3/3/20 at 9:11 A.M. showed the following: -A 108 ounce (oz.) can of pork and beans dented on the bottom, a 101 oz. can of collard greens heavily dented on the side and bottom, a 104 oz. can of sliced apples dented on the side and bottom, and a 108 oz. can of applesauce dented at the top, were all on a can dispenser rack with other undented cans in the Dry Storage room. -Bits of plastic, paper, and cardboard were on the floor under the racks in the dry storage. -A red, a brown, and a white cutting board were all heavily scored with minute bits of plastic hanging on, and the white cutting board also had brown streaks stained on it. -The green plate warmer lids and bottoms were discolored and/or chipping. -There was a large chunk of food and paper residue on the manual can opener. -The toaster had excessive crumbs in the bottom and underneath. -The resident microwave in the dining room adjoining the kitchen had food splatters on the inside top, bottom, door, and sides. During an interview on 3/4/20 at 9:49 A.M., the Dietary Supervisor said the following: -Whoever puts the food stock away should check for damaged food stuffs and take a picture of it for credit from the vendor. -Food preparation equipment and utensils should be cleaned after each use by whoever used them. -Floors are to be swept by the dietary staff at the end of shift. -If any plastic items are damaged, cracked, or chipped they should be thrown away when found and replaced.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the staff was [MEDICATION NAME] hand hygiene at mealtime by not cleansing their hands between assisting different residents to eat for one sampled resident (Resident #64) and two supplemental residents (Resident #41 and Resident #62) out of 16 sampled residents; the facility failed to establish and maintain a comprehensive, facility-specific infection prevention and control program designed to help prevent the development and transmission of waterborne pathogens (a bacterium, virus, or other microorganism that can cause disease), and to provide documented assessments for such an outbreak, in accordance with Centers for Medicare and Medicaid Services (C[CONDITION]) guidelines. This deficient practice had the potential to affect all residents, visitors, and staff who reside in, visit, use, or work in the facility. The facility census was 64 with a licensed capacity for 87 residents. Record review of the facility's Policy for Handwashing, dated 2019 showed: -Nursing staff must comply to the hand washing policy. -Hand washing is not limited to handling food or snack. -Hand washing is not limited to washing hands after touching ear, nose, or mouth. -Alcohol based hand rubs cannot be used in place of proper hand washing techniques in a food service setting. -Hands are to be washed before and after handling food. -Hands are to be washed before and after assisting a resident with meals (with soap and water). 1. Record review of the facility's EP manual entitled Disaster Manual reviewed by the Administrator on 2/17/20 and obtained from the second floor nurse station showed an absence of any waterborne pathogen prevention program including, but not limited to, the following: -A facility-specific risk assessment that considers the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard. -A completed Centers for Disease Control (CDC) toolkit including control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens. -A schematic or diagram of the facility's water system. -A facility-specific infection prevention program or plan to deal with outbreaks of [CONDITION] and/or other waterborne pathogens. -A program and flowchart that identifies and indicates specific potential risk areas of growth within the building. -Assessments of each individual potential risk level. -Testing protocols and acceptable ranges for control measures with a method of monitoring them specifically at this facility. -Facility-specific interventions or action plans for when control limits are not met. -Documentation of any site log book being maintained with any cleanings, sanitizings, descalings, and inspections mentioned. During an interview on 3/4/20 at 2:05 P.M., the Maintenance Supervisor said that he/she did not believe the facility had a waterborne pathogen prevention program. During an interview on 3/5/20 at 10:49 A.M., the Administrator said the facility did not have a waterborne pathogen prevention program. 2. Observation on 3/2/20 at 12:15 P.M. of the assisted dining room (lunch meal) showed: -Certified Nursing Assistant (CNA) A was assisting Resident #62 with eating. -CNA A scratched his/her stomach under his/her shirt. -Without cleansing his/her hands, CNA A picked up Resident #62's cup, and with contaminated hands, gave Resident #62 a drink. -With contaminated hands, CNA A tucked his/her hair out of his/her face. -CNA A did not cleanse his/her hands. -With contaminated hands, CNA A fed the Resident #62 his/her carrots. -With contaminated hands, CNA A turned Resident #41's plate around. -CNA A did not cleanse his/her hands. -With contaminated hands, CNA A gave Resident #62 a drink. -CNA A scratched his/her neck. -CNA A did not cleanse his/her hands. -With contaminated hands, CNA B was feeding Resident #64. -CNA B scratched his/her head. -CNA B put his/her hands on his/her face. -CNA B did not cleanse his/her hands. -With contaminated hands, CNA B fed Resident #64 his/her mashed potatoes. -CNA B cleansed his/her hands with hand sanitizer. -CNA B wiped his/her eye. -CNA B did not cleanse his/her hands. -With contaminated hands, CNA B continued to feed Resident #64. -CNA B rubbed his/her lip with his/her left hand. -CNA B did not cleanse his/her hands. -CNA B played with his/her hair. -CNA B did not cleanse his/her hands. -With contaminated hands, CNA B continued to feed Resident #64. -CNA B used hand sanitizer to cleanse his/her hands. During an interview on 3/2/20 at 1:00 P.M. with Licensed Practical Nurse (LPN) B said: -You are supposed to wash your hands between feeding residents. -You should not touch hair or pants without washing your hands. 3. Observation of the breakfast meal on 3/5/20 at 07:30 A.M. from 7:52 A.M. of the assisted dining room showed: -CNA C opened a carton of milk to pour it on Resident #64's cereal. -CNA C pulled up his/her pants. -CNA C did not cleanse his/her hands. -CNA C scratched his/her hair. -CNA C did not cleanse his/her hands. -With contaminated hands, CNA C continued to feed Resident #64 without cleansing hands. During an interview on 3/5/20 at 2:00 P.M. CNA C said: -The facility does training on handwashing. -You should not touch hair, pants, or face without washing your hands while feeding the residents. During an interview on 3/6/20 at 2:32 P.M. the Director of Nursing (DON) said: -He/she would not expect the staff to touch any part of their body and not wash their hands while assisting the residents to eat. -The staff has had education on handwashing.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer influenza and/or pneumococcal immunizations; to provide documentation the resident or the resident's representative refused the immunizations or provide a medical reason the immunizations could not be administered, and to document the history of these vaccines having been offered or administered before being admitted to the facility for three sampled residents (Residents #36, #46, and #57) out of 16 sampled residents. The facility census was 64 residents. Record review of the facility policy, Influenza and Pneumococcal Immunizations, dated 2006 showed: -The residents or his/her family/legal representatives will be provided educational instructions regarding the benefits of immunization as well as the potential for side effects prior to consenting to

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F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) receive the immunizations. -Refusal of immunization will be honored by the facility upon consent agreement. -The resident and/or his/her legal representatives have the right to refuse or accept the offer of immunizations. -The staff would explain to the residents and family the benefits of the immunization. -The staff was to document the reason the resident did not receive the immunization. 1. Record review of Resident #36's face sheet showed he/she was re-admitted on [DATE] with the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION] ([MEDICAL CONDITION] - an [MEDICAL CONDITION] lung disease that causes obstructed airflow from the lungs). -Dyspnea (a shortness of breath related to heart or lung disease). -Obstructive sleep apnea (a disorder in which breathing starts and stops repeatedly during sleep). -Pulmonary fibrosis (when lung tissue becomes damaged or scarred). -[MEDICAL CONDITION] (a condition in which you lack enough healthy red blood cells to carry [MED]gen to the body's tissues). -The resident was not his/her own person. Record review of the resident's Admission Minimum Data Set (MDS- a federally mandated assessment tool completed by the facility for care planning) dated [DATE] showed he/she: - Was mildly cognitively impaired with a BI[CONDITION] (brief interview for mental status) of 11 out of 15. -Was offered and declined the influenza vaccine. -Was not current with his/her pneumococcal vaccine. -Was offered and declined the pneumococcal vaccine. -Had [MEDICAL CONDITION]. -Had [MEDICAL CONDITION]. Record review of the resident's care plan dated [DATE] showed the staff was to follow the physician's orders. Record review of the Physician's Order Sheet (POS) dated March 2020 showed: -The resident had an order to receive the Influenza immunization (Flu vaccine) annually unless contraindicated. -Last date Flu vaccine was given was blank. -Last date [MEDICATION NAME] vaccine (pneumococcal vaccine) was given was blank. -The [MEDICATION NAME] vaccine should be given every five years. Record review of the resident's Immunization Report dated [DATE] - 3/31/20 showed: -The resident had refused the Influenza immunization. -The resident had refused the [MEDICATION NAME] immunization. -No documentation the facility staff provided the resident or the resident's representative written education, or the risks and benefits of the influenza and pneumococcal vaccines. Record review of the resident's medical record showed: -No documentation the resident had a previous history if the resident had received the influenza or pneumococcal vaccines. -No documentation if the resident had a medical reason for not receiving the influenza and pneumococcal vaccines. -No documentation the resident or the resident's representation had refused the influenza and pneumococcal vaccines. 2. Record review of Resident #46's face sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -[MEDICAL CONDITION]. -The resident had a guardian. Record review of the resident's Annual MDS dated [DATE] showed he/she: -Was cognitively intact with a BI[CONDITION] of 15 out of 15. -Had Diabetes. -had [MEDICAL CONDITION]. -Was offered and declined the influenza vaccine. -Was not current with his/her pneumococcal vaccine. -Was offered and declined the pneumococcal vaccine. Record review of the resident's care plan dated 1/29/20 showed the staff was to the follow the physician's orders. Record Review of the POS [REDACTED]. -The last date the Flu vaccine was refused was 10/19/19. -The last date the [MEDICATION NAME] was given was 1/16/14. --The [MEDICATION NAME] vaccine should be given every five years. Record review of the resident's Immunization Report dated [DATE] - 3/31/20 showed: -The resident had refused the Influenza immunization. -No documentation the facility staff offered the resident or the resident's guardian to provide the resident a pneumococcal vaccine. -No documentation the facility staff provided the resident or the resident's guardian written education, or the risks and benefits of the influenza and pneumococcal vaccines. Record review of the resident's medical record showed: -No documentation if the resident had a medical reason for not receiving the influenza and pneumococcal vaccines. -No documentation the resident or the resident's guardian had refused the influenza and pneumococcal vaccines. 3. Record review of Resident #57's face sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -The resident had a guardian. Record review of the resident's Annual MDS dated [DATE] showed he/she: -Was cognitively intact with a BI[CONDITION] of 12 out of 15. -Was not current with his/her pneumococcal vaccine. -Was offered and declined the pneumococcal vaccine. -Had [MEDICAL CONDITION]'s disease. Record review of the resident's care plan dated [DATE] showed: -The staff was to follow the physician's orders (11/12/19). -The resident was difficult to understand. -If the resident was resistive to care, do not continue, notify charge nurse. Record review of the Physician's Order Sheet (POS) dated March 2020 showed: -Last date [MEDICATION NAME] vaccine was given was blank. -The resident had an order to receive the [MEDICATION NAME] every five years. Record review of the resident's Immunization Report dated [DATE] - 3/31/20 showed: -The resident had refused the [MEDICATION NAME]. -No documentation the facility staff provided the resident or the resident's guardian written education, or the risks and benefits of the pneumococcal vaccines. Record review of the resident's medical record showed: -No documentation if the resident had a medical reason for not receiving the pneumococcal vaccine. -No documentation the resident or the resident's guardian had refused the pneumococcal vaccine. 4. During an interview on 3/5/20 at 10:21 A.M. the Director of Nursing (DON) said: -A local pharmacy came in to give the influenza immunizations. -The [MEDICATION NAME] was given by the MDS Coordinator/LPN. -The MDS Coordinator was responsible for keeping track of the immunizations. -The nurses could give the immunizations. -It should have been charted if a resident had refused. During an interview on 3/6/20 at 10:32 A.M. the Administrator said: -The physician orders the Influenza immunizations. -The Influenza immunizations were done annually. -The physician orders the [MEDICATION NAME] immunizations. -The [MEDICATION NAME] immunizations were given every five years. -Information about the immunization was provided before the shot was given. -If the resident refused, they were educated on the benefits of having it. -The nurse would try again to get the resident to receive the immunization. -The MDS coordinator was responsible to keep track of the immunizations. -The Influenza immunizations were given by a local pharmacy. -The Administrator did chart audits to ensure the immunizations were given. -The charts were also audited every three months when the MDS has been done. During an interview on 3/6/20 11:10 A.M. Licensed Practical Nurse (LPN) A said: -The Director of Nursing (DON) keeps track of the immunizations. -The MDS coordinator gives the immunizations. -A local pharmacy gave the Influenza immunizations this last year. During an interview on 03/06/20 at 12:28 P.M. the MDS Coordinator said: -There was no documentation of education provided to resident or guardian if they had refused the immunizations. -It was his/her responsibility to keep track of this. -He/she did not do it. -He/she also did not provide education if the guardian agreed and the resident then refused. -He/she did not have the resident sign the form when they refused. -(Education about the benefits were on the form).