STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676095	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST OAKS NURSING AND REHABILITATION CENTER	3200 W. SLAUGHTER LANE AUSTIN, TX 78748

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 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to receive and track grievances through to their conclusion and ensure prompt efforts were made to resolve resident grievances for two of the five Residents reviewed (Resident #27 and Resident # 32) for grievances. A. The facility did not document, track, and make efforts to promptly resolve Resident #27's request for her air conditioner to be repaired. B. The facility did not document, track, and make efforts to promptly resolve Resident #32's request for his bed to be made earlier in the day. These failures could affect the resident by placing them at risk for psychological harm due to diminished self-esteem and physical harm due to diminished quality of life/accommodation of needs. Findings to include: A. Review of the Face Sheet for Resident #27 reflected an [AGE] year-old male who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident # 27 dated 1/3/20 reflected a BI[CONDITION] of 10 indicating intact/borderline cognition. Review of the MDS Section G functional status reflected Resident # 27 needed extensive assistance with bed mobility, transfer, and walking in the room and corridor. Review of the Care Plan for Resident #27 dated 12/31/19 reflected interventions ADL self-care performance deficit, which included encouraging residents to participate to the fullest extent possible with each interaction. Review of maintenance log for the past three months reflected that there was no order to fix resident # 27 air conditioner. During an interview conducted on [DATE]20 at 3:43 p.m., Resident # 27 stated that he had communicated to the ADM several times that his air conditioner wasn't working properly. He stated that no one had come to check the air conditioner. He stated that the staff didn't communicate to him how they resolved his concerns. During an interview conducted on 3/11/20 at 3:00 p.m., The Maintenance Director stated that he was not aware that Resident #27 had a complaint about the odor of the air conditioner. He stated that the facility staff or resident could verbally notify him or write down on the maintenance log any repair it needed. B. Review of the Face Sheet for Resident #32 reflected a [AGE] year-old male who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident # 32 dated 1/15/20 reflected a BI[CONDITION] of 10 indicating intact/borderline cognition. Review of the MDS Section G functional status reflected Resident # 32 needed extensive assistance with transfer, dressing, and walking in the room and corridor. Review of the Care Plan for Resident # 32 dated 10/29/18 reflected interventions ADL self-care performance deficit, which included assistance during bathing, dressing, and toilet use. Review of complaint/grievance report dated 12/9/19 reflected that Resident #32's daughter complained that the resident's bed was not made. Review of grievance's resolution section revealed no notes or any documentation. During an interview conducted on [DATE] at 4:00 p.m., Resident #32 and Resident's FM stated that they had complained to staff about Residents #32's bed not being made until late in the day. Resident #32 stated that sometimes staff made his bed until 3:00 p.m. During a confidential group interview resident stated that they did not get any feedback after grievances. Resident stated that the facility staff would write down the grievance, and there would be no follow up. The resident stated that the facility did not provide any reason for not following up. The residents stated that they didn't have a resolution of their grievances. During an interview conducted on 3/11/20 at 6:25 p.m., the ADM stated residents can file grievances or staff could help the resident file grievances. He stated that the facility staff is responsible for conducting an investigation and addressing all grievances. He stated that the staff should go back to the resident and inform them of the resolution. ADM stated that he expects the complaint, investigation, and resolution to be documented on the grievance form. Review of facility, complaint/grievance Policy undated read in part: The resident, responsible party, an/or legal representative have the right to voice grievances without discrimination or reprisal. 1. A complaint/ grievance report form should be completed for every complaint voiced by resident, responsible party, and/or legal representative. 2. Upon receipt of complaint submit the form to the facility administrator or designated staff for follow-up. Prompt effort by facility will be made to resolve all grievances. Notify appropriate state agencies as needed. 3. The facility will maintain a monthly log to document all grievances. 4. Prompt effort by facility will be made to resolve all grievances. 5. Resident responsible party, and/or legal representative will be notified of resolution
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 observation, interview and record review the facility failed ensure that respiratory care was provided consistent with professional standards for four (#344, #83, #62, and #100) of 22 residents reviewed for respiratory care. 1. The facility failed to develop a care plan that accurately reflected [MED]gen needs for Resident #344. 2. The facility failed to develop a care plan that accurately reflected [MED]gen needs for Resident #83. 3. The facility failed to develop a care plan that accurately reflected [MED]gen needs for Resident #62. 4. The facility failed to develop a care plan that accurately reflected [MED]gen needs for Resident #100. This failure could place the health and safety of all residents at risk for not receiving necessary care and services. Findings include: 1. Review of Resident #344 face sheet reflected an [AGE] year old man admitted on [DATE] with [DIAGNOSES REDACTED]. [MEDICAL CONDITION] Fibrillation, Gastro-[MEDICAL CONDITION] Reflux Disease, an Other Constipation. Review of Resident #344 care plan dated 02/08/2020 reflect no interventions for [MED]gen therapy. Review of Resident #344 order dated 03/06/2020 reflected that he receive [MED]gen via nasal canula at 2 liters per minute as needed for shortness of breath/saturations below 90%. Observation on 03/09/2020 at 11:45 am revealed Resident #344 sitting in a wheelchair using [MED]gen concentrator and nasal cannula. Observation on 03/09/2020 at 11:51 am revealed Resident #344 take his nasal cannula off and scratch and rub his nose. Observation on 03/09/2020 at 11:52 am revealed Resident #344 revealed no water for humidifier on [MED]gen concentrator and no filter on [MED]gen concentrator. Observation of 03/09/2020 at 11:54 am revealed Resident #344 take his nasal cannula off and rub his nose. During an interview on 03/09/2020 at 11:51 am, Resident #344 stated that his nose felt dry. During an interview on 03/09/2020 at 11:54 am, Resident stated that his nose normally gets dry and bothered him when using his [MED]gen concentrator. 2. Review of Resident #62 face sheet revealed a [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #62 admission MDS dated [DATE] reflected a BI[CONDITION] score of 11 which indicated a moderate impairment. Further review of MDS, Section O, reflected Resident #62 is received [MED]gen therapy in the 14 days prior to the MDS. Review of physician orders [REDACTED].#62's [MED]gen concentrator filter be checked for placement and cleanliness every week on Sunday and as needed. Review of Resident #62 care plan dated 02/04/2020 reflected no interventions for [MED]gen therapy or maintenance of [MED]gen concentrator. Observation on 03/09/2020 at 9:24 AM revealed that Resident #62 laid in bed and used his [MED]gen concentrator with nasal canula in place. Observation on 03/09/2020 at

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 9:31 AM revealed white grime on Resident #62 [MED]gen concentrator filter. During an interview on 03/09/2020 at 9:25 am, Resident #62 stated that he has a lot of pain in his knees and ankles and he is currently at the facility for therapy. Resident #62 stated that he used [MED]gen. 3. Review of Resident #83 face sheet revealed a [AGE] year old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #83 quarterly MDS dated [DATE] reflected a BI[CONDITION] score of 12 which indicated a moderate impairment. Further review of MDS reflected that Resident #83 had an active [DIAGNOSES REDACTED]. Review of MDS, Section O, reflected no [MED]gen therapy received by Resident #83. Review of Resident #83 care plan dated 02/06/2020 reflected resident #83 had [MEDICAL CONDITION] with a goal to display optimal breathing patterns daily. Interventions included give aerosol or [MEDICATION NAME][MEDICATION NAME] as orders and monitor for side effects and effectiveness, identify and eliminate sources of respiratory irritation such as cigarette smoke, pollen, perfumes, etc., monitor for difficulty breathing, monitor of signs or symptoms of acute respiratory insufficiency. Further review reflected no interventions for [MED]gen use or to monitor [MED]gen stats. Review of Resident #83 physician order [REDACTED].#83 received up to 4 liters of [MED]gen via nasal canula as needed to keep [MED]gen stats between 88 and 92 for [MED]gen maintenance. Review of Resident #83 physician order [REDACTED].#83 respirations, pulse and [MED]gen stats and lung sounds prior to nebulizer treatments. Observation of Resident #83 [MED]gen concentrator on 03/09/2020 at 2:59 pm revealed that [MED]gen concentrator only had one of two filters on [MED]gen concentrator and undated humidifier water on concentrator. 4. Review of Resident #100 face sheet reflected a [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #100 care plan dated 03/05/2020 reflected Resident #100 has limited physical mobility related to weakness secondary to [MEDICAL CONDITION]. Further review of Resident #100 care plan reflected no interventions related to [MED]gen use or concentrator maintenance. Review of Resident #100 physician orders [REDACTED].#100 received [MED]gen at 2 liters per minute via nasal canula to keep [MED]gen saturation levels above 92%. Review of Resident #100 physician orders [REDACTED].#100 [MED]gen tubing and water be changed every Sunday and as needed. Observation on 03/09/2020 at 10:53 am revealed Resident #100 had undated humidifier water on concentrator. During interview on 03/09/2020 at 10:50 am Resident #100 stated that he was here due to gangrene on his foot. Resident s#100 stated that he was not feeling well today. During and interview on 03/11/2020 at 4:11 PM, CNA A stated that she has worked at the facility for four months. CNA A stated that she used care plans to tell her how to transfer a resident, if they used [MED]gen, if they are supposed to assess for pain and for shower information. During an interview on 03/11/2020 at 4:14 PM, CNA B stated that he used care plans to determine what the resident needed. He stated that he checked with nurses for information regarding [MED]gen use and if he saw a concern with [MED]gen he would notify the nurse. CNA B stated that he used care plans to review what needed to be done with a resident and how much care or type or care the resident needed. During an interview on 03/11/2020 at 4:18 PM, LVN C stated that she has been an employed at the facility since February 2019 she stated that care plans provide information about the care of the resident, if they use [MED]gen, information about their medications, behaviors and diagnoses. LVN C stated that it paints a picture of who the resident is and what they need. She stated that it lets staff know the care to provide for the resident. LVN C stated that care plan are a big communication piece in resident care and it tells staff almost anything they needed to know that has to do with the resident's care. She stated that if a resident used [MED]gen she would expect that to be a part of the care plan. During an interview on 03/11/2020 at 5:03 PM, the DON stated that nurses used care plans and CNAs used Kardex. Kardex tells the specifically about care of the resident. DON stated that what is on the care plan gets translated or set up on Kardex. She stated that the care plan tells the nurses the plan of care and tell them the interventions that are tried. DON stated that the care plan outlines what care a resident needed. She stated that certain medications such as anti-psychotic medications, [MEDICATION NAME] and [DIAGNOSES REDACTED]. DON stated I guess I could say yes when asked if information about [MED]gen and related interventions should be included on the care plan. DON stated if the resident has [MEDICAL CONDITIONS] or PRN [MED]gen and to check [MED]gen stats then it would be included in the care plan. DON stated maintenance things are not included in the care plan, such as changing filters, but only information about the patient. DON stated that all nurses including nurse managers, ADONs, MDS and the social worker are responsible for updating care plans. When asked how often care plans are updated, the DON stated during morning meets if something is going on with resident care then the plan is updated then. She stated that general updates should be updated the same day of the findings. She stated that it is her expectation that that care plans accurately reflect the resident's needs including medication needs and non-maintenance [MED]gen needs. During an interview on 03/11/2020 at 6:18 pm, the ADM stated that it is his expectation that resident care should be care planned and he considered [MED]gen needs as resident care. Review of facility Care Planning policy from Nursing Services Policy and Procedure Manual dated December 2017 reflected that a comprehensive, person-centered care plan is developed and implemented for each resident to meet the resident's physical, psychosocial and functional needs. Further review reflected that the care plan is developed by the care planning and interdisciplinary team which includes, the registered nurse responsible for the resident, the director of nursing, the charge nurse responsible for resident care and nursing assistants.
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 observation, interview and record review, the facility failed to ensure that treatment was received in accordance with professional standards for 1 (#45) of 22 residents reviewed for quality of care. 1. The facility failed to ensure Resident #45's [DEVICE] were pressurized at the level prescribed by physician. This failure could result in residents not receiving treatment for [REDACTED]. Findings include: Review of Resident #45 face sheet reflected a [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of admission MDS dated [DATE] reflected a BI[CONDITION] score of 14 indicating no cognitive impairment. Review of MDS, Section M Skin Conditions, reflected that Resident #45 received skin and ulcer/injury treatments for surgical wound care, application or nonsurgical dress and applications of ointments/medications. Review of Resident #45 care plan dated 01/27/2020 reflected Resident #45 had ADL self-care performance deficit related to weakness secondary to chronic leg ulcers, Resident #45 has acute pain related to leg ulcers, and that Resident #45 has a venous/stasis ulcer of the right shin with wound vac placement. Intervention included to document location of wound, drainage amount, pain, [MEDICAL CONDITION], and evaluate wound for infection, necrosis, gangrene, size and to place wound vac to absorb moisture as ordered. Review of Resident #45 physician's orders [REDACTED]. physician's orders [REDACTED]. Further review of physician's orders [REDACTED]. Review of progress note dated 03/11/2020 reflected, per the wound care clinic, increased discomfort could be a negative outcome of the wound vac set for 150mmHg. Observation on 03/09/2020 at 10:56 am revealed that Resident #45 [DEVICE] were pressurized at a rate of 150mmHg. During an interview on 03/09/2020 at 10:56 am, Resident #45 stated that he did not think his [DEVICE] were draining. He stated that his pumps are normally at 120. Resident stated that he believed he had faulty pumps and that the staff was not doing anything about it. During an interview on 0[DATE]20 at 3:23 pm, Resident #45 stated that he never changed the rates on his [DEVICE] or anything on the machines and stated that the nurses are the ones to change the machines. During an interview on 03/11/2020 at 3:05 pm, with the DON stated that Resident #45 requested scissions this morning to cut bandages off. DON stated that Resident #45 would mess with his dressing. DON stated that the [DEVICE] pull of liquid and that Resident #45 goes to the wound clinic every Monday. The DON stated that she did not know if there would be a negative consequence if the wound vac was pumping at a higher rate. The DON stated that it is her expectation that it should be pumping at the rate it is ordered. During an interview on 03/11/2020 at 6:18 pm, the ADM stated that it is his expectation that the wound vac matches the order and run at the rate it was ordered at. Quality of care policy was not provided by facililty.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed ensure that respiratory care was provided consistent with professional standards for 4 (#344, #83, #62, and #100) of 22 residents reviewed for respiratory care. 1. The facility failed to ensure that Resident #344 had a filter for his [MED]gen concentrator and water for his humidifier. 2. The facility failed to ensure that Resident #62's [MED]gen concentrator filter was clean. 3. The facility failed to ensure that Resident #83 had two of two filters for her [MED]gen concentrator and that her humidifier water was dated. 4. The facility failed to ensure that Resident #100's humidifier water was dated. This failure could place residents receiving respiratory care at risk of air not being filtered properly and could result in [MEDICAL CONDITION] and or discomfort. Findings include: 1. Review of Resident #344 face sheet reflected an [AGE] year old man admitted on [DATE] with [DIAGNOSES

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) REDACTED]. [MEDICAL CONDITION] Fibrillation, Gastro-[MEDICAL CONDITION] Reflux Disease, an Other Constipation. Review of Resident #344 care plan dated 02/08/2020 reflect no interventions for [MED]gen therapy. Review of Resident #344 order dated 03/06/2020 reflected that he receive [MED]gen via nasal canula at 2 liters per minute as needed for shortness of breath/saturations below 90%. Observation on 03/09/2020 at 11:45 am revealed Resident #344 sitting in a wheelchair using [MED]gen concentrator and nasal cannula. Observation on 03/09/2020 at 11:51 am revealed Resident #344 take his nasal cannula off and scratch and rub his nose. Observation on 03/09/2020 at 11:52 am revealed Resident #344 revealed no water for humidifier on [MED]gen concentrator and no filter on [MED]gen concentrator. Observation of 03/09/2020 at 11:54 am revealed Resident #344 take his nasal cannula off and rub his nose. During an interview on 03/09/2020 at 11:51 am, Resident #344 stated that his nose felt dry. During an interview on 03/09/2020 at 11:54 am, Resident stated that his nose normally gets dry and bothered him when using his [MED]gen concentrator. 2. Review of Resident #62 face sheet revealed a [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #62 admission MDS dated [DATE] reflected a BI[CONDITION] score of 11 which indicated a moderate impairment. Further review of MDS, Section O, reflected Resident #62 is received [MED]gen therapy in the 14 days prior to the MDS. Review of physician orders [REDACTED].#62's [MED]gen concentrator filter be checked for placement and cleanliness every week on Sunday and as needed. Review of Resident #62 care plan dated 02/04/2020 reflected no interventions for [MED]gen therapy. Observation on 03/09/2020 at 9:24 AM revealed that Resident #62 laid in bed and used his [MED]gen concentrator with nasal canula in place. Observation on 03/09/2020 at 9:31 AM revealed white grime on Resident #62 [MED]gen concentrator filer. During an interview on 03/09/2020 at 9:25 am, Resident #62 stated that he has a lot of pain in his knees and ankles and he is currently at the facility for therapy. Resident #62 stated that he used [MED]gen. 3. Review of Resident #83 face sheet revealed a [AGE] year old female admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #83 quarterly MDS dated [DATE] reflected a BI[CONDITION] score of 12 which indicated a moderate impairment. Review of Resident #83 care plan dated 02/06/2020 reflected resident #83 had [MEDICAL CONDITION] with a goal to display optimal breathing patterns daily. Interventions included give aerosol or [MEDICATION NAME][MEDICATION NAME] as orders and monitor for side effects and effectiveness, identify and eliminate sources of respiratory irritation such as cigarette smoke, pollen, perfumes, etc., monitor for difficulty breathing, monitor of signs or symptoms of acute respiratory insufficiency. Further review reflected no interventions for [MED]gen use. Review of Resident #83 physician order [REDACTED].#83 received up to 4 liters of [MED]gen via nasal canula as needed to keep [MED]gen stats between 88 and 92 for [MED]gen maintenance. Review of Resident #83 physician order [REDACTED].#83 respirations, pulse and [MED]gen stats and lung sounds prior to nebulizer treatments. Observation of Resident #83 [MED]gen concentrator on 03/09/2020 revealed that [MED]gen concentrator only had one of two filters on [MED]gen concentrator and undated humidifier water on concentrator. 4. Review of Resident #100 face sheet reflected a [AGE] year old male admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #100 care plan dated 03/05/2020 reflected Resident #100 has limited physical mobility related to weakness secondary to [MEDICAL CONDITION]. Review of Resident #100 physician orders [REDACTED].#100 received [MED]gen at 2 liters per minute via nasal canula to keep [MED]gen saturation levels above 92%. Review of Resident #100 physician orders [REDACTED].#100 [MED]gen tubing and water be changed every Sunday and as needed. Observation on 03/09/2020 at 10:53 am revealed Resident #100 had undated humidifier water on concentrator. During interview on 03/09/2020 at 10:50 am Resident #100 stated that he was here due to gangrene on his foot. Resident s#100 stated that he was not feeling well today. During an interview on 03/11/2020 at 1:19 pm, the DON stated that the [MED]gen concentrators do not have to have a humidifier and that it is more for comfort, but if a resident is experiencing symptoms of discomfort they should have water for the humidifier. DON stated that normally the facility puts humidifier water on every machine and change the water every Sunday might. She stated that she is unsure if Resident #344 had dry nasal passages when he came and could have received nasal saline as needed had Resident #344 complained about his nose. The DON stated that the water on [MED]gen concentrators should be dated when they change the water and tubing. DON stated that there is not facility policy or procedure and it is her expectation the facility follows nursing standards. The DON stated that the standard is to date the water when it is changed. The DON stated that water and tubing is changed every Sunday or as needed. The DON stated that there is not facility policy regarding the maintenance of [MED]gen concentrators, but rather there are batch orders to clean filters weekly and as needed on the concentrators. The DON acknowledged the picture of Resident #83's concentrator missing a filter and no water on concentrator. The DON acknowledged picture of white grime on Resident #62 [MED]gen concentrator filter. The DON acknowledged picture of Resident #83 [MED]gen concentrator only having one filter out of two and undated water on the concentrator. The DON acknowledged that Resident #100 had undated water on concentrator. During an interview on 03/11/2020 at 6:18 pm, the ADM stated that it is his expectation that facility nurses follow nursing standards and they should label and date water for [MED]gen concentrators when they are changed. Facility had no policy regarding [MED]gen concentrator care. Review of Perry, Potter and Ostendorf's Clinical Nursing Skills and Techniques dated 2013 reflected to check [MED]gen equipment for safety and function at least once per shift. Further review reflected that [MED]gen administration should be treated like any administered medication and to follow the six rights of medication administration. Further review reflected to always document accurately at the time of administration.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to assure drugs and biologicals were secured properly for one of one treatment carts observed in that: A. A treatment cart was left unlocked and unattended in the 100 hallway during wound care observation. B. A nurse medication cart was left unlocked and unattended in the 100 hallway during blood glucose observation. This deficient practice could place all residents at risk for not receiving the intended therapeutic benefit of treatments, risk of exposure to hazards and for drug diversion. Findings include: A. Observation on 3/11/2020 at 10:59AM revealed the treatment cart outside room [ROOM NUMBER] was left unlocked when LVN A entered resident's room to perform wound care. During an interview on 3/11/2020 at 11:11AM LVN A confirmed that the cart was unlocked; LVN A then pressed button to lock the cart. LVN A stated anytime she leaves the cart she is to lock the cart and the computer screen. B. Observation on 3/11/2020 at 11:28AM revealed the nurse medication cart outside room [ROOM NUMBER] was left unlocked when LVN B entered residents room to perform blood glucose testing. During an interview on 3/11/2020 at 11:32AM LVN B confirmed that the cart was unlocked; LVN B then pressed button to lock the cart. LVN B stated she is to always lock the cart and screen when she walks away from cart. During an interview on 3/11/2020 at 2:32PM DON stated her expectation is that if staff are not with the cart, it should be locked. Policy for Label/Store Drugs and Biologicals requested, facility did not provide.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation and record review, the facility failed to ensure that each resident received foods that were palatable and appetizing temperature for three of three residents (Resident #27, #32, and #71) reviewed in that: The facility failed to serve food at an appetizing temperature. These failures could affect the residents who ate in their meals prepared by the facility kitchen by placing them at risk of weight loss, altered nutritional status, and diminished quality of life. Finding included: Review of the Face Sheet for Resident #27 reflected an [AGE] year-old male who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident # 27 dated 1/3/20 reflected a BI[CONDITION] of 10 indicating intact/borderline cognition. Review of the MDS Section G functional status reflected Resident # 27 needed extensive assistance with bed mobility, transfer, and walking in the room and corridor. Review of the Care Plan for Resident #27 dated 12/31/19 reflected interventions ADL self-care performance deficit, which included encouraging residents to participate to the fullest extent possible with each interaction. Review of the Face Sheet for Resident #32 reflected a [AGE] year-old male who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent MDS for Resident # 32 dated 1/15/20 reflected a BI[CONDITION] of 10 indicating intact/borderline cognition. Review of the MDS Section G functional status reflected Resident # 32 needed extensive assistance with transfer, dressing, and walking in the room and corridor. Review of the Care Plan for Resident # 32 dated 10/29/18 reflected interventions ADL self-care performance deficit, which included assistance during bathing, dressing, and toilet use. Review of the Face Sheet

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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 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) for Resident # 71 reflected an [AGE] year-old female who was admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #71's MDS dated [DATE] reflected that BI[CONDITION] score of 7 indicating moderately impaired. Review of Section K, Swallowing/Nutritional Status, reflected that resident has no signs and symptoms of possible swallowing disorder. Review of the Care Plan for Resident # 71 dated 10/31/18 reflected interventions for ADL self-care performance deficit which included encourage resident to participate to the fullest extent possible interaction. Review of the resident council minutes form date 9/30/19 reflected that the residents complained that food was cold. Review of the resident council minutes form date 10/25/19 reflected that the residents complained that food was cold. Review of the resident council minutes form date 1/31/20 reflected that the residents complained that food and coffee were cold. During an observation conducted in the kitchen on [DATE] at 11:49 a.m. reveled. DA took the temperatures of spinach and bacon which were 141 F, macaroni 147F, and pure bread 153F. Further observation reflected DM taking the spinach and bacon temperature which was 141F. Futher observation reflected DA reheating the food at the stove. During an interview conducted on 3/09/20 at 11:50 a.m., KM stated that holding temperatures for food should be 165F and that she will reheat the food. During an interview conducted on 3/09/20 at 11:55 a.m., KM stated that the spinach and bacon temperature should be 165F. During an interview conducted on 3/09/20 at 3:36 p.m., Resident # 71 stated that the food is cold. During an interview conducted on 3/09/20 at 3:43 p.m. Resident # 27 stated that the food is always cold and that he had complaint about it to the staff several times. During a confidential group interview resident stated that their food is cold at all meals. Residents stated that their food is cold when they eat in the dining hall and in their rooms. During an interview conducted on [DATE] at 4:00 p.m. Resident # 32 stated that food is cold especially the room's food trays. During an interview conducted on 3/11/20 at 2:36 p.m., KM stated that she is present at the majority of the resident council meetings. She stated that the AA provided her with a copy of the resident council minutes. She stated that she had not receive any complaint about the cold food. During an interview conducted on 3/11/20 at 3:23 p.m., AA stated that she is aware that the resident had complaint about cold food. She stated that the resident had told the KM during the resident council meetings. She stated that she doesn't provide the resident council minutes to the KM. She stated that she had verbally inform the KM that the residents had complained about cold food. During an interview conducted on 3/11/20 at 6:24 p.m., ADM stated that the food temperature should meet the required guidelines and it should be palatable. Review of facility, taking food temperatures Policy dated 2018 read in part: If a potentially hazardous food is not at the proper temperature, further investigation is undertaken to determine how long the doo has been outside the safe temperature zone to determine if it is safe to restore the food to the correct temperature.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were completely and accurately documented for two (#344 and #36) of 22 residents whose records were reviewed for accuracy and completeness. 1. The facility failed to verify active [DIAGNOSES REDACTED]. 2. The facility failed to include [MEDICAL CONDITIONS] and [MEDICAL CONDITION] on Resident # 36's face sheet. Resident #36 was prescribed [MEDICATION NAME] [MED] 500 mg for [MEDICAL CONDITION], [MEDICATION NAME] 25mg and [MEDICATION NAME] 200mg for [MEDICAL CONDITION], and [MEDICATION NAME] 25mg for [MEDICAL CONDITION]. These failures could place residents at risk of not receiving the necessary or accurate care and services needed due to inaccurate and or incomplete clinical records. Findings include: 1. Review of Resident #344 face sheet reflected an [AGE] year old man admitted on [DATE] with [DIAGNOSES REDACTED]. [MEDICAL CONDITION] Fibrillation, Gastro-[MEDICAL CONDITION] Reflux Disease, an Other Constipation. Review of Resident #344 care plan dated 02/08/2020 reflected that Resident #344 had a [MEDICAL CONDITION] related to [MEDICAL CONDITIONS] with interventions to assess for signs and symptoms of [MEDICAL CONDITION]. Additional interventions included to monitor for changes in respiratory rate or depth, signs and symptoms of upper respiratory infection, pneumonia, [CONDITION], decreased cardiac output pneumothorax, SIADH, decreased renal perfusion, increased intracranial pressure, and hepatic congestion. Review of Resident #344 physician's orders [REDACTED]. Review of Resident #344 physician's orders [REDACTED]. Observation on 03/09/2020 at 11:45 am revealed Resident #344 sitting in a wheelchair using [MED]gen concentrator and nasal cannula. During an interview on 03/11/2020 at 1:19 PM, the DON acknowledged that the indication of [MEDICAL CONDITION] on the [MEDICAL CONDITION] order did not match Resident #344 [DIAGNOSES REDACTED].#344 had [MEDICAL CONDITION] [DIAGNOSES REDACTED]. 2. Review of Resident # 36 face sheet reflected a [AGE] year-old female admitted on [DATE] with [DIAGNOSES REDACTED]. and Mobility, Pain in Right Elbow, Lack of Coordination, [MEDICAL CONDITION] Disorder, Anxiety Disorder, Contracture Left Hand, Muscle Weakness, [MEDICAL CONDITION] Not Due to a Substance or Known Physiological Condition, Overactive Bladder, and [MEDICAL CONDITION]. Review of Resident #36 most recent MDS dated [DATE], reflected a BI[CONDITION] score of 13 indicated no cognitive impairment. Further review of, Section I Active Diagnoses, revealed that the resident had anxiety, [MEDICAL CONDITION] disorder, and [MEDICAL CONDITION]. Review of the Care Plan for Resident #36 reflected interventions dated 3/01/2017 for [MEDICAL CONDITION] disorder included to monitor, record, and report to physician episodes of feelings or sadness, depression, anxiety, and sad mood. Review of Resident #36's orders dated 01/14/20 reflected that that resident was getting [MEDICATION NAME] [MED] 500 mg, 1 tablet once a day for [MEDICAL CONDITION]. Review of Resident #36's orders dated 01/22/20 reflected that that resident was getting [MEDICATION NAME] 25mg, 3 tablets once a day for [MEDICAL CONDITION]. Review of Resident #36's orders dated 01/22/20 reflected that that resident was getting [MEDICATION NAME] 200mg, 1 tablets twice a day for [MEDICAL CONDITION]. Review of Resident #36's orders dated 1/22/20 reflected that that resident was getting [MEDICATION NAME] 25mg, 1 drop in both eyes for [MEDICAL CONDITION] at bedtime. During an interview on 03/11/2020 at 1:26 pm, the DON stated that the order should have a matching indicator on the [DIAGNOSES REDACTED]. The DON stated that if the resident got [DIAGNOSES REDACTED]. The DON stated that if a resident is taking a routine anxiety medication the resident should have an active [DIAGNOSES REDACTED]. Review of facility Charting and Documentation policy from Nursing Services Policy and Procedure Manual dated December 2017 reflected that all services provided to the resident, progress towards the care plan goals, or any changes in the resident's medical, physical, function or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Further review of this policy reflected that documentation in the medical record may be electronic, manual, or a combination.