STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265455	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLARD CARE CENTER	400 WEST WALNUT LANE WILLARD, MO 65781

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one resident (Resident #31) had an appropriate wheelchair for safety and comfort out of a selected sample of 17 residents. The facility's census was 52. 1. Record review of Resident #31's face sheet (a document that gives a resident's information at a quick glance) showed the resident admitted to the facility on [DATE]. His/her [DIAGNOSES REDACTED]. Record review of the resident admission Minimum Data Set (MDS), a federally mandated comprehensive assessment instrument completed by facility staff, dated 12/10/19, showed the following information: -Severe Cognitive impairment; -Dependent on staff for bed mobility, transfer, locomotion, and for activities of daily living; -Impairment of range of motion of both lower extremities and of one upper extremity; -Used a wheelchair for mobility; -[DIAGNOSES REDACTED]. Record review of the resident's Care Plan, dated 1/20/2020, showed: -The resident was dependent on staff for activities of daily living (ADL) (i.e. dressing, hygiene, bathing) (except eating) related to dementia, post-polio syndrome and general weakness. -Staff will anticipate and meet resident's needs while maintaining dignity; -The resident used a wheelchair for mobility, which staff propelled; -The resident had contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in both of his/her lower extremities, both of his/her legs draw up towards his/her chest when he/she lays in bed. An observation on 3/2/20, at 1:27 P.M., showed the resident sat in his/her wheelchair in the dining room. His/her wheelchair did not have foot pedals. The resident's legs dangled as his/her feet did not reach floor. An observation on 3/3/20, at 3:30 P.M., showed resident sat in his/her wheelchair near the nurses' station. His/her wheelchair did not have foot pedals. The resident's legs dangled as his/her feet did not reach floor. An observation and an interview on 3/4/20, at 12:53 P.M., showed the following: -Certified Nursing Assistant (CNA) F and CNA G assisted the resident into bed. The resident had contractures of his/her right and left knee and right hip. His/her right leg bent in and up towards his/her chest. His/her left knee bent slightly. -CNA F attempted to straighten the resident's left leg and the resident said hey. The CNA gently laid the resident's leg onto the bed. -CNA F said the resident had contractures of both legs but he/she could straighten the left leg more than the right. -CNA F and CNA G said staff removed the foot pedals from the resident's wheelchair because he/she bent his/her knees and the foot pedals were a safety concern. -The resident's left outer ankle had four approximately 2-inch scabbed lacerations. -The frame of the resident's wheelchair, where the foot pedals attached to the frame, had protruding [MEDICATION NAME] hardware which could injure the resident. Record review of the resident's progress nurses' notes showed no documentation staff removed the foot pedals from the resident's wheelchair and showed no documentation staff identified the four scabs on the resident's left outer ankle. During an interview on 3/4/20, at 12:24 P.M., Licensed Practical Nurse (LPN) B said on admission, the nurses assessed residents for an appropriate wheelchair. The resident has contractures of both of his/her legs, but the contractures are worse on the resident right leg. Staff removed the foot pedals from the resident's wheelchair because he/she hit his/her legs on the foot pedals. The LPN did not know why the resident was not evaluated for alternate foot pedals. During an interview on 3/5/20, at 1:31 P.M., Registered Nurse (RN) E said: -If the resident admitted to the facility without a wheelchair, the facility had wheelchairs a resident could use. If the facility did not have a wheelchair that fit a resident's specific need, the Director of Nursing (DON) would assess the resident to determine the next course of action. The facility could rent a wheelchair if needed. Physical therapy/Occupational therapy would also get involved but he/she did not know when. -Resident #31 did not have any special needs that required a specialized wheelchair. -The RN did not know why the resident's wheelchair did not have foot pedals. -The RN did not know of any injuries related to the resident's foot pedals. During an interview on 3/5/20, at 3:06 P.M., CNA H said: -If a resident could pick up his/her feet when the aides propelled his/her wheelchair, the resident did not need foot pedals, if a resident could not pick up his/her feet, the resident needed foot pedals on his/her wheelchair. -If the aides noticed a problem with a resident's wheelchair, the aides reported the problem to the charge nurse. -Resident #31's wheelchair did not have foot pedals because the resident's legs did not reach foot pedals. -The CNA did not know of any injuries to the resident's legs or ankles. During an interview on 3/6/20, at 9:21 A.M., LPN B said: -If a resident admitted to the facility without a wheelchair, the nurse could get a wheelchair from storage. The LPN determined the appropriate wheelchair by the resident's height and weight. If wheelchair did not fit the resident, staff tried a different one. -Physical therapy and Occupational therapy staff assessed residents' needs for alternative wheelchair accessories or equipment when a resident had a problem such sliding down in his/her chair. -Resident 31's wheelchair initially had foot pedals, but his/her feet hit the pedals. Nursing staff decided removed the foot pedals from the resident's wheelchair for his/her safety. -The resident's feet did not touch the floor due to the resident's contractures and dangled from the wheelchair seat. -The LPN did not know of any injuries to the resident as a result of no foot pedals. -Staff did not consult with physical therapy or occupational therapy about a foot pedal alternative for the resident's wheelchair. During an interview conducted on 3/6/20, at 11:09 A.M., the rehabilitation director said therapy staff assessed residents' wheelchair needs if nursing or a physician requested it. The rehabilitation director did not know anything about Resident #31's wheelchair or his/her foot pedals. The main reason for foot pedals was for positioning. During an interview on 3/6/20, at 11:30 A.M., the Director of Nursing (DON) said the following: -If a resident admitted to the facility without a wheelchair, the facility provides a wheelchair for the resident. The staff used the resident's height and weight to determine the appropriate wheelchair. -When a resident admitted to the facility, occupational therapy (OT) and physical therapy (PT) screened the resident for services. If the resident needed a specialized wheelchair, nursing staff talked to OT/PT in the weekly weekly meeting. -If a resident needed equipment in between weekly meetings, staff begin brainstorming alternatives for the resident. Therapy could become involved then. Nursing staff would involve anyone that would be of assistance. -The Resident #31 had contractures of his/her legs. Staff placed foot pedals on his/her wheelchair several times but he/she kept rubbing a scab or nicking his/her ankles, so nursing staff thought it would better to remove the foot pedals from his/her wheelchair. The amount of time the resident was out of bed was very limited because he/she had a large wound on his/her buttocks. -Staff removed the foot pedals from the resident's wheelchair within the first two weeks after his/her admission to the facility.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to electronically transmit encoded Minimum Data Set (MDS) (a federally mandated assessment instrument completed by facility staff) assessments from the facility to the Centers for Medicare & Medicaid Services (CMS) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system within 14 days after completion for three residents (Resident #1, Resident #2, and Resident #18) out of a

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 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) sample of 17 residents selected for review. The facility had a census of 52 residents. The facility did not have a policy regarding transmitting MDS data. 1. Record review of Resident #'1's face sheet (a document that gives a resident's information at a quick glance) showed the following information: -Readmitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's quarterly MDS assessment, due 1/18/20 and completed on 2/17/20, showed staff encoded the MDS assessment data into the facility system, but did not electronically transmit the encoded MDS information to the QIES ASAP System within 14 days. 2. Record review of Resident #2's face sheet showed the following information: -Readmitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's quarterly MDS assessment, due 7/24/19 and completed on 10/1/19, showed staff encoded the MDS assessment data into the facility system, but did not electronically transmit the encoded MDS information to the QIES ASAP System within 14 days. Record review of the resident's annual MDS assessment, due 1/24/20 and completed on 2/17/20, showed staff encoded the MDS assessment data into the facility system, but did not electronically transmit the encoded MDS information to the QIES ASAP System within 14 days. 3. Record review of Resident #18's face sheet showed the following information: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's quarterly MDS assessment, due 9/2/19 and completed on 10/16/19, showed staff encoded the MDS assessment data into the facility system, but did not electronically transmit the encoded MDS information to the QIES ASAP System within 14 days. Record review of the resident's quarterly MDS assessment, due 12/2/19 and completed on 1/1/20, showed staff encoded the MDS assessment data into the facility system, but did not electronically transmit the encoded MDS information to the QIES ASAP System within 14 days. 4. During an interview on 3/5/20 at 11:36 A.M., the MDS coordinator said the following: -She completed the MDS assessments which included entry, discharge, admission, significant change, quarterly and annual assessments; -She used a calendar or a report to ensure she completed the assessments timely; -She submitted the assessments once a week; -She knew she submitted the MDS assessments late and was trying to fix the problem. 5. During an interview on 3/5/20 at 12:04 P.M., the administrator said she knew the MDS coordinator submitted the MDS assessments late and had addressed the problem with the MDS coordinator.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #31), with limited range of motion, received appropriate treatment and services to prevent a further decrease in range of motion in a selected sample of 17 residents. The facility's census was 52. 1. Record review of Resident #31's face sheet (a document that gives a resident's information at a quick glance) showed staff admitted the resident to the facility on [DATE]. The resident's [DIAGNOSES REDACTED]. Record review of Resident #31's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/10/19, showed the following information: -Severe cognitive impairment; -Dependent upon staff for bed mobility, transfers, dressing, personal hygiene and bathing; -Resident had impaired functional ROM of both lower extremities and impaired functional ROM one upper extremity; -Used a wheelchair for mobility; -Did not participate in a restorative program. Record review of resident's medical record showed no documentation staff provided the resident with ROM exercises. Record review of the resident's Care Plan, dated 1/20/2020, showed: -Dependent on staff for all ADLS (except eating) related to dementia, post-polio syndrome (gradual new weakening in muscles that were previously affected by the polio infection), and general weakness. -Required maximum assist of two with all transfers. -Contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in both lower extremities and his/her lower extremities were drawn up towards his/her chest when he/she is laid in bed. -Staff turn and reposition the resident every two hours and as needed when he/she was in bed. -Staff dressed the resident every morning and evening. -Physical therapy (PT), Occupational therapy (OT), and the Restorative Nurse Program (RNP) would evaluate and treat per physician order [REDACTED].M., showed the resident laid in bed on his/her left side with his/her with knees pulled up towards his/her chest. An observation and an interview on 3/4/20, at 12:53 P.M., showed the following: -Certified Nursing Assistant (CNA) F and CNA G assisted the resident into bed. The resident had contractures of his/her right and left knee and right hip. His/her right leg bent in and up towards his/her chest. His/her left knee bent slightly. -CNA F said the resident had contractures of both legs but his/her left leg could be somewhat straightened if done slowly; his/her right leg could not be straightened. CNA F attempted to straighten the resident's left leg and the resident said hey. The CNA stopped and gently laid the resident's leg onto the bed. -CNA F said the resident's right arm was paralyzed, the resident could not move it on his/her own. -CAN F said the CNAs performed ROM for all residents daily when they provided care, but there was not any specific number of repetitions or a schedule. The CNAs did not document routine ROM exercises. -CNA F said he/she performed ROM exercises on the resident's arm and his/her legs when the resident sat in his/her wheelchair. He/she moved the resident's left leg up and down, like the resident was dancing but did not move the resident's right leg much since it was more contractured than the left. He/she also performed ROM on the resident's legs when he/she laid in bed. If the resident knew you were performing ROM, he/she would not want to do it. If the aide distracted the resident, the resident allowed the aide to perform ROM. -CNA G said the resident did not participate in the facility's restorative nursing program. During an interview on 3/4/20, at 12:24 P.M., Licensed Practical Nurse (LPN) B said: -The admitting nurse assessed residents for any special needs. -If a resident had a decline in his/her condition or if he/she fell , the nurse notified the physician who would write an order for [REDACTED]. -Resident #31 had contractures of both lower extremities and his/her right arm was flaccid due to post-polio syndrome. -The resident was not a therapy candidate due to comorbidities, dementia and refusal. During an interview on 3/4/20, 1:05 P.M., RNA G said she worked as the facility's RNA for two to three weeks. When therapy wrote a resident's restorative plan, he/she gave it to him/her and he/she added the resident to the restorative list. During an interview on 3/4/20, at 1:35 P.M., CNA F said if a resident needed restorative therapy, staff talked with therapy staff who developed a restorative plan. Therapy gave he plan to the DON who passed it to the RNA to implement. Observation on 3/5/20, at 9:11 A.M., showed the resident laid in bed on his/her left side with his/her legs pulled up, towards his/her chest. During an interview on 3/5/20, at 1:31 P.M., Registered Nurse (RN) E said: -The resident had contractions of both of his/her hips and knees, and a contracture on his/her right upper arm. -The restorative nurse aide (RNA) performed ROM exercises with the resident, but he/she did not know how often or if there was a schedule. -During wound care, the nurses would stretch the resident's lower extremities; -Staff notified the charge nurse if a resident's ROM decreased. The charge nurse assessed the resident and contacted the physician. The physician either assessed the resident or ordered a therapy evaluation. -Splints and ROM exercises could be implemented to prevent further contractures. -If a resident received hospice services, he/she did not qualify for restorative care. During an interview on 3/5/20, at 3:06 P.M., CNA H: -Staff performed ROM exercises with residents when the resident laid in bed. -The CNA knew who to provide ROM with based on how the resident moved. -The restorative nursing assistant (RNA) was supposed to provide ROM exercises to the residents. -CNA H did not perform ROM exercises on Resident #31 due to the CNA's fear of the resident's leg contractions. During an interview on 3/6/20, at 11:09 A.M., the Rehabilitation Director (RD) said the following: -Therapy staff completed a therapy screen on residents to determine if a resident qualified or needed therapy services on admission, quarterly, and with any major changes (such as falls or a decline). -If a resident received hospice services, he/she did not qualify for therapy services. -A therapist developed a restorative nursing plan if a resident did not qualify for skilled therapy, could not complete an ordered skilled therapy, or just completed therapy; -When Resident #31 admitted to the facility, staff thought he/she would start Hospice services. When the resident did not, therapy screened him/her. Therapy staff did not request therapy services for the resident due to concerns that his/her wound would worsen, and fear of the misuse of funding (if resident was to be placed on hospice). -The RD thought once the resident's wound healed, he/she would receive hospice services due to low cognition. -The RD did not feel comfortable developing restorative plan for the resident because of his/her wound. -Stretching would be the only benefit for the resident. The facility was short on aides. The concern for the resident should be focused on wound care more than stretching. -Since the resident admitted to the facility in December 2019, he/she should be on the quarterly (March 2020) therapy screening list. -The RD knew the resident needed serviced to prevent further deterioration of his/her current contractures, and that was something to look at during the resident's quarterly screening. During an interview on 3/6/20, at 11:30 A.M., the DON said: -All CNAs could perform ROM exercises with a resident. -All staff knew to perform ROM when they got a resident up, dressed, or with any ADL that would be similar in movement. -If staff noticed changes in a resident's ROM, he/she reported the change to the charge nurse and the DON. -If staff notified the DON, she

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) would discuss it in the weekly team meeting. A therapist attended the meeting so if the team agreed, therapy staff would screen the resident for therapy services.
F 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 to ensure proper cleaning and maintenance of a BiLevel Positive Airway Pressure ([MEDICAL CONDITION]) (a non-invasive form of therapy for people suffering from sleep apnea (temporary cessation of breathing, especially during sleep)), failed to develop and implement interventions for use of a [MEDICAL CONDITION] and failed to obtain a physician order for [REDACTED]. Record review of the facility's Bilevel Positive Airway Pressure ([MEDICAL CONDITION]) Administration policy, dated March 2015, showed the following information: -Purpose: To administer positive airway pressure to maintain an open airway to the resident with obstructive apnea (repeated episodes of complete or partial obstructions of the upper airway during sleep, despite the effort to breathe, and is usually associated with a reduction in blood oxygen saturation) or respiratory problems, primarily during sleep; -Guidelines: Care and use of the [MEDICAL CONDITION] machine with cleaning mask, headgear, tubing and humidifier same as the Continuous Pressure Airway Pressure ([MEDICAL CONDITION]) (a form of positive airway pressure ventilator, which applies mild air pressure on a continuous basis) guidelines. Record review of the facility's [MEDICAL CONDITION] administration policy, dated March 2015, showed the following information: -Check the physician's order for pressure setting and method of administration; -Care and use of the [MEDICAL CONDITION] machine: Use a wet cloth or cleaning wipe to clean the outside surface of the [MEDICAL CONDITION] machine. For a reusable filter: Clean the back filter weekly by running it under warm water, squeezing the water out of it until it runs clear of dust; replace this filter with a new one once a year. -Cleaning masks, headgear, tubing and humidifier: For safety, unplug the unit when cleaning. Begin with wiping the outside of the [MEDICAL CONDITION] unit with damp cloth. Let air dry. Inspect the filters on the unit: one filter is usually a foam material that is easily taken out from the device by pinching the middle of the foam. The filter should be cleaned with water and mild soap once every two weeks of use. The inner filter that is ultra-fine should be replaced every 30 days. If it appears dirty before 30 days, replace it. -The tubing should be cleaned weekly. Particles from the air can gather in the tubing through use, and mold can even accumulate which is dangerous to inhale. Remove the tubing from the device and rinse with water and mild soap, swishing the water back and forth through the tube and emptying. Rinse thoroughly and air dry. -The mask and nasal pillows connection can be wiped daily with a damp cloth and mild soap. Rinse and allow to air dry; -If the unit has a humidifier, check to make sure there is enough distilled/tap water in the unit. Clean the holding tank with a damp cloth and mild soap weekly. For disinfecting the holding tank, use vinegar and water mix and let it sit in the holder for approximately 30 minutes. Rinse thoroughly and air dry. Record review of the facility's Oxygen Administration policy, dated March 2015, showed the following information: -Check physician's order for liter flow and method of administration; -Check resident's respiration and observe at regular intervals to assess need for further oxygen therapy after oxygen has been discontinued. 1. Record review of Resident #18's face sheet (a document that gives a patient's information at a quick glance) showed the following information: -admitted to the facility 2/20/17; -[DIAGNOSES REDACTED]. [MEDICAL CONDITION] can make you feel tired and weak), [MEDICAL CONDITIONS] (a chronic [MEDICAL CONDITION] lung disease that causes obstructed airflow from the lungs) and [MEDICAL CONDITION] disorder (a chronic mental health condition characterized primarily by symptoms of [MEDICAL CONDITION], such as hallucinations or delusions, and symptoms of a mood disorder, such [MEDICAL CONDITION] depression). Record review of the resident's physician order sheet showed an order dated 2/20/17, for a Bi-Level machine of 19.0 centimeters (cm)/14.0 cm water, heated humidifier at bedtime (6:00 P.M. - 6:00 A.M.). Record review of the resident's care plan, last revised/reviewed on 4/3/19 showed the following: -The resident could perform his/her own activities of daily living (ADLS), but needed help at night getting up and using the bathroom; -Short-term goal: 3/10/20 staff would assist the resident with all ADLS to the extent required while promoting independence and maintaining dignity; -The resident slept with a [MEDICAL CONDITION] at night related to sleep apnea. The resident could apply the [MEDICAL CONDITION] by himself/herself; -Remind the resident and encourage him/her to ask for assist with the [MEDICAL CONDITION] as needed. (The care plan did not address disinfection and care of the [MEDICAL CONDITION] machine, mask, tubing, filters, and humidifier). Record review of the resident's quarterly Minimum Data Set (MDS), a federally mandated comprehensive assessment instrument, dated 12/2/19, showed the following information: -No cognitive impairment; -Independent with bed mobility, transfers, walking, dressing, personal hygiene, eating and bathing; -Used a walker or wheelchair for mobility; -Shortness of breath or trouble breathing with exertion (walking, bathing, transferring); -Did not use Oxygen or a [MEDICAL CONDITION]/[MEDICAL CONDITION]. Record review of the resident's February 2020 and March 2020 Medication Flow Sheet showed staff documented the resident used the Bi-Level Machine, heated humidifier, daily at bedtime (6:00 P.M. to 6:00 A.M.) every night. (The medication flow sheet did not include when to clean the [MEDICAL CONDITION]'s tubing, reservoir, mask or filters). During an interview on 3/2/20, at 1:44 P.M., the resident said staff did not clean his/her [MEDICAL CONDITION], he/she did. Record review of the resident's progress note, dated 3/4/20 showed staff documented the resident called the facility and told them he/she was in the emergency room . At his/her appointment, he/she became white as a ghost, had shortness of breath and high blood pressure. The resident returned to the facility at 12:30 A.M. with a [DIAGNOSES REDACTED]. During an interview on 3/4/20 at 2:28 P.M., the resident said he/she went to the hospital on [DATE] and returned on 3/4/20 in the early morning. He/she had to get Oxygen due to shortness of breath. Record review of the resident's physician orders did not show an order for [REDACTED]., Registered Nurse (RN) E said the following: -The resident used a [MEDICAL CONDITION] at night. The resident applied and maintained the [MEDICAL CONDITION] independently. -Every day the resident obtained distilled water, from staff, to fill the [MEDICAL CONDITION]'s reservoir. -The nurse did not know how often or when the resident cleaned the [MEDICAL CONDITION] and did not know when the tubing was changed. -The nursing protocol included instruction for cleaning a [MEDICAL CONDITION]. -The nurse did not know when the resident's [MEDICAL CONDITION] was calibrated. -The nurse thought the resident was trying to get a new [MEDICAL CONDITION]. The nurse did not know the specifics of that process because the resident set up and went to all of his/her own appointments. An observation on 3/5/20, at 3:04 P.M., showed the resident positioned in bed, with his/her eyes closed, wearing his/her [MEDICAL CONDITION] mask. There was not a date on the machine or tubing to indicate when it was cleaned or changed. During an interview on 3/06/20, at 9:21 A.M., Licensed Practical Nurse (LPN) B said the resident used a [MEDICAL CONDITION] at night and during the day when napping. The resident cleaned and maintained his/her [MEDICAL CONDITION] independently. The LPN did not know if the resident cleaned the machine and tubing but thought he/she did. An observation on 3/6/20, at 10:22 A.M., showed the resident sat in a wheelchair in the hall. An oxygen tank and tubing was secured to the back of the wheelchair. The resident did not use the Oxygen at that time. During interview on 3/6/20, at 10:22 A.M., the resident said the following: -He/she cleaned his/her [MEDICAL CONDITION] tubing with soapy water once a week, and deep cleaned it with full strength vinegar once a month. He/she filled the hose with either soap and water or vinegar and swished it back and forth for 5 minutes, then rinsed with water. He/she often asked an aide to assist him/her with the swishing. He/she placed the clean tubing on towels and draped the tubing over the side table to drain. Sometimes he/she moved the tubing to the railing on the side of the bed to finish drying. -The resident rinsed the reservoir with hot water daily and cleaned it with straight vinegar every two to three weeks. -The [MEDICAL CONDITION] had a filter but he/she did not clean it often because he/she forgets about it. He/she thought he/she cleaned it approximately two to three weeks ago. -He/she cleaned the mask with ivory soap and hot water weekly. He/she placed the mask in the windowsill to dry, with the vents blowing on it. -He/she replaced the [MEDICAL CONDITION] mask, tubing, reservoir and filter last Thursday or Friday. -The [MEDICAL CONDITION] was calibrated once since admission. -He/she started using oxygen this week after his/her spell. The Nurse Practitioner told him/her to use it as needed, at 2 Liters via nasal cannula. He/she did not use oxygen much, but had used it. The resident did not know how long he/she would require the oxygen. During an interview on 3/6/20, at 11:30 A.M., the Director of Nursing (DON) said: -The resident admitted to the facility with a [MEDICAL CONDITION]. The [MEDICAL CONDITION] settings were preset. -The resident cleaned his/her [MEDICAL CONDITION] weekly. He/she did not want staff to do it. Staff assisted the resident with cleaning as needed. -The facility provided the resident vinegar and distilled water for cleaning and maintaining his/her [MEDICAL CONDITION]. -The facility did not want to be intrusive to the resident's wishes. -If a resident required oxygen, staff would call the physician to obtain an order that included Oxygen dosage and length of time. -Staff probably placed the Oxygen tank on the back of the resident's wheelchair to make the resident feel better. It was probably recommended by an Optum representative (the resident's insurance), which the facility complied with.

F 0740 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.**

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F 0740 **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 observation, interview, and record review the facility failed to meet the psychosocial needs of one resident (Resident #27) who had a [DIAGNOSES REDACTED]. The facility's census was 52. Record review of Resident #27's face sheet showed the resident originally admitted on [DATE]. Record review of the resident's current physician orders [REDACTED]. Record review of the resident's Social Services New Admission Minimum Data Set (MDS) (a federally mandated comprehensive assessment tool completed by facility staff) assessment note dated 9/23/19, at 1:28 P.M., showed the following: -The Resident and Social Services Director (SSD) completed the basic interview for mental status (BIMS) and mood interview; -The resident scored a 10/15 on the BIMS indicating his/her cognition was moderately impaired; -The resident scored a 9/27 on the mood interview indicating he/she had mild depression; -The resident denied: having little interest/pleasure in doing things; having thoughts of being better off dead/wanting to hurt herself; -The resident said he/she felt depressed and tired/had little energy. every day. -He/she had trouble sleeping since he/she arrived to the facility. He/she said It's not as quiet as home. -The resident felt bad about himself/herself because he/she was tired and had little energy; -He/she had felt depressed for a long time, ever since his/her spouse passed away three years ago. They were together for [AGE] years. The resident said It hasn't been the same and it won't ever be the same. -SSD would relay the depression score to the charge nurse. Review of the resident's progress nurse notes showed staff did not document a follow-up regarding the depression score or notification of the resident's physician of the score. Record review of the resident's physician visit note, dated 10/7/19, showed: -[DIAGNOSES REDACTED]. life. Record review of the resident's physician visit note, dated 11/14/19, showed: -[DIAGNOSES REDACTED]. life. Record review of the resident's Social Services Quarterly MDS Assessment progress note dated 12/24/19, at 1:30 P.M., showed: -Resident completed sections C and D of the MDS Assessment with the SSD; -The resident scored a 12/15 on the BIMS indicating moderately impaired cognition; -The resident scored a 16/27 on the mood interview indicating he/she had moderately severe depression; -SSD informed the charge nurse of the score; -Resident said he/she had little interest or pleasure in doing things, felt down/depressed/hopeless due to his/her spouse had not been gone that long and the memories of this time of year, and also because of moving here and selling his/her home; -The resident said he/she would get out of it. (Referring to the depression and sadness he/she felt); -SSD asked the resident how he/she would do it and the resident said he/she would work on it. -SSD told the resident that happy memories could be made here, especially since there were so many happy, friendly people; -The resident said he/she loved people; -SSD talked with the resident a little bit more, and received smiles and laughs. Record review of the resident's quarterly MDS, dated [DATE], showed the following: -Resident scored a 16 on the patient health questionnaire indicating he/she had moderately severe depression which warranted active treatment with psychotherapy, medications, or a combination. Review of the resident's progress nurse notes showed staff did not document follow-up regarding the depression score or notification of the resident's physician of the score. Record review of the resident's care plan, updated 1/4/20, showed: -The resident was at risk for adverse reaction related to antidepressant use for his/her [DIAGNOSES REDACTED]. Monitor for effectiveness. Monitor resident for signs and symptoms of adverse reactions. Ongoing assessment with physician and pharmacy to ensure the resident received a therapeutic dose of antidepressants. Monitor the resident's labs and functional status. Record review of the resident's physician visit note, dated 1/14/20, showed: -[DIAGNOSES REDACTED]. life. During an interview on 3/4/20 at 3:35 P.M., the resident said the following: -He/she felt depressed. He/she lost his/her spouse a few years ago and was not over that, Life is just not the same. -The resident frequently dreamed about his/her spouse, woke up and felt sad, -Sometimes the resident laid in bed at night and thought about sad things; -Staff had not offered the resident a therapist or psychologist; -The resident denied suicidal ideation. During an interview on 3/4/20 at 3:45 P.M., the SSD said the following: -Without looking at the resident's medical record, she could not remember if the resident was depressed or not; -If a resident scored high on the mood interview, felt depressed, showed little or no interest in doing things, was suicidal, or felt hopeless, the SSD would let the resident's nurse know and the nurse would follow up with the physician; -The SSD did not follow up with the nurse to ensure the nurse communicated with the resident's physician or what the outcome was; -If the physician ordered a psychiatric evaluation, the nurse notified the SSD to schedule the appointment/arrangements for the evaluation. During an interview on 3/4/20 at 3:50 P.M., Licensed Practical Nurse (LPN) B said the following: -The resident was friendly to the nurse, but sometimes had a flat affect (A severe reduction in emotional expressiveness); -If the SSD assessed a resident as being depressed, the SSD took a sticky note to the desk to notify the nurse. The nurse then notified the resident's physician; -The nurse should document the conversation with the resident's physician in the nurse's notes; -The nurse did not remember the SSD notifying him/her the resident felt depressed. During an interview conducted on 3/6/20, at 11:30 A.M., the Director of Nursing said the following: -The SSD social completed the mood assessment and questionnaire with the resident. -The SSD reported the findings to the charge nurse and to the department heads during the weekly meeting. -The SSD wrote the resident's mood score on a sticky note and gave it to the charge nurse. She also verbally reported the score to the charge nurse. -The charge nurse then reported the score and the SSD's findings to the physician. The charge nurse asked the physician, if he/she wanted to change or add anything. -If the charge nurse obtained a new order from the physician, the nurse should document, in the nurses notes, he/she obtained a new order based on the resident's mood score. -If the physician wrote an order for [REDACTED].
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff administered medications with an error rate of less than five percent when staff made two errors out of 34 opportunities, resulting in an error rate of 5.88 percent affecting two residents (Resident #26 and #38). The facility's census was 52. 1. Record review of Resident #26's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's Medication Administration Record [REDACTED]. An observation on 3/4/20 at 12:00 P.M., Certified Medication Technician (CMT) A opened one [MEDICATION NAME] (a medication used to treat [MEDICAL CONDITION] and some mood disorders) 125 mg capsule, placed the contents of the capsule in a small amount of yogurt in a medicine cup, and administered the medication to the resident with a spoon. During an interview on 3/4/20 at 12:00 P.M., CMT A said he/she crushed the resident's medications prior to administration. Record review of the resident's physician order [REDACTED]. During an interview on 3/4/20 at 2:30 P.M., CMT A said the nurse contacted the resident's physician and obtained a new order for [MEDICATION NAME] Sprinkles capsules, which is what staff had been giving the resident. The pharmacy previously sent the [MEDICATION NAME] Sprinkles capsules instead of the [MEDICATION NAME] tablets that were ordered and staff were administering the capsules in error. 2. Record review of Resident #38's face sheet showed the following: -admitted to the facility on [DATE]; -His/her [DIAGNOSES REDACTED]. Record review of the resident's March 2020 physician order [REDACTED]. Observations on 3/5/20 showed the following: -At 9:18 A.M., CMT A prepared Resident #38 medications for administration. CMT A removed a bottle of Vitamin D3, 10 mcg (400 units) and placed two tablets (20 mcg (800 units) in a medication cup. The CMT administered the medication to the resident, whole, with a cup of water. -At 9:30 A.M., while the CMT prepared another resident's medication, he/she noticed the Vitamin D3 bottle contained 10 mcg (400 units) and not 25 mcg (1000 units). The CMT asked the Director of Nursing to obtain a bottle with the correct dosage. The CMT removed the 10 mcg (1400 unit) bottle from the medication cart. 3. During an interview on 3/6/20 at 11:30 A.M., the DON said staff should administer medications per physician's orders [REDACTED].
F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide routine and 24-hour emergency dental care for each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to address one resident's (Resident #21) dental needs failed to document regarding dental pain, broken teeth, or other dental needs for the resident in a selected sample of 17 residents. The facility's census was 52. Record review of the facility's policy, dated March 2015, titled Oral Hygiene, showed the following information: -Offer oral hygiene before breakfast, after each meal and at bedtime. -Inspect mouth and gums for irritation or open areas. 1. Record review of Resident #21's face sheet (a document that gives a resident's information at a quick glance) showed the following information: -Readmitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's Physician order [REDACTED]. Record review of the resident's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 6/11/19, showed the following information: -Moderately Impaired Cognition; -Required extensive assistance with personal

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	265455	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLARD CARE CENTER	400 WEST WALNUT LANE WILLARD, MO 65781

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F 0790 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) hygiene; -Obvious likely cavity or broken teeth. Record review of the resident's Care Plan, dated 11/18/19, showed: -Monitor for signs or symptoms of chewing or swallowing problems as resident has natural teeth in poor condition, with few missing. -The resident has his/her own natural teeth, several are missing and the others are in poor condition. -Set up and assist the resident with all of his/her personal hygiene needs. -He/she needs assistance I need help with oral care after meals, at bedtime and as needed. Record review of the resident's current medical showed no documentation of follow-up regarding the resident's broken teeth. Observation and interview on 3/2/20, at 3:47 P.M., showed the resident sat in a recliner in his/her room. r\The resident had his/her own natural teeth. His/her teeth were in poor condition as he/she had some missing, and broken teeth and possible dental carries. The resident said he/she had dental pain at times, but had a dental appointment that afternoon (according to the resident's medical record, the resident did not have a dental appointment, and there were no upcoming appointments scheduled). During an interview on 3/4/20, at 2:31 P.M., of resident said he/she still had dental pain but had not reported it to the nurse or anyone else yet. During an interview on 3/5/20, at 1:31 P.M., Registered Nurse (RN) E said: -On admission, the admitting nurse assessed the resident's teeth and reported any concerns to the physician or social services designee (SSD); -There was no formal follow-up with a dentist after admission. Residents were only seen if staff reported a concern. -Certified nursing assistants (CNAs) reported, to the nurse, residents' oral concerns, including bleeding or swollen gums, dentures that did not fit, and dental decay. -The nurse assessed the resident, and notified the physician of any dental concerns. The physician would order a dental consult, if needed. The SSD sets-up residents' dental appointments. -The nurse did not know the resident had any dental concerns, including mouth/dental pain. The resident admitted to the facility with broken teeth. During an interview on 3/5/20, at 3:06 P.M., Certified Nurses' Aide (CNA) H said: -CNAs ask residents if they want to wash and swish their mouth out after eating. The CNAs encourage residents to brush their teeth as well. -If the CNAs observed any dental issues, they notified the charge nurse and the Director of Nursing (DON). -Reportable issues included pain and broken dentures, and anything the resident reported to the them (the CNAs). -Resident #21 had his/her own natural teeth and usually refused brushing his/her teeth. The resident would swish and spit. -Resident refused assistance with brushing his/her teeth, and could brush his/her teeth without assistance. -The resident had not complained to the CNA H of tooth pain or discomfort. During interview on 3/6/20, at 9:08 A.M., CNA F said: -The CNAs report any dental issues to the charge nurse, including bleeding gums and chewing problems; -Resident #21 had his/her own natural teeth. The resident admitted with poor dentition. -The resident would usually brush his/her teeth after meals with assistance. -The resident had not reported to the CNA any issues with his/her teeth. During interview on 3/6/20, at 9:21 A.M., Licensed Practical Nurse (LPN) B said: -Staff tried to assist each resident with dental hygiene. -The CNAs should report any bleeding, blisters, sores, or anything abnormal to the nurse for assessment. -After the nurse assessed the resident, he/she notified the physician for an order. The nurse would give the SSD the order to make referral to a dentist. -Dentists did not come to the facility. -The resident had poor dentations, and sometimes complained of pain but not always. -The resident's family member knew the condition of the resident's teeth. Before the resident admitted to the facility, the family member made an appointment for the resident to see a dentist. The resident refused at that time. The LPN did not remember if the resident's family member told him/her or if another staff member told him/her. The LPN did not know if anyone documented the information in the resident's progress notes. -The LPN did not notify anyone of the resident's occasional dental pain and did not know if any other staff had reported it. If staff reported the resident's dental issues, he/she would document it in the resident's progress notes. During an interview conducted on 3/6/20, at 10:24 A.M., the SSD said the following: -If a resident or resident's family reported dental issues to a nurse, the nurse could either talk to the SSD or discuss the need in the care plan meeting. -If a resident had dental concerns, the SSD would ask the resident, or the resident's DPOA, if appropriate, if he/she wanted the SSD to set-up an appointment. -Staff should document all reported dental issues in the resident's progress notes. -If a resident needed a dental appointment, but either he/she or his/her DPOA refused, staff should document the refusal in the resident's progress notes. -Neither staff nor the resident's durable power of attorney reported to him/her (the SSD) the resident needed a dental referral, and the resident had not complained to him/her of any dental issues. During an interview on 3/6/20, at 11:30 A.M., the DON said: -Staff monitored residents' dental for any signs or symptoms of dental issues including mouth sores, bleeding gums, and tooth pain; -If a resident had any dental concerns, the charge nurse notified the resident's physician; -Sometimes the physician would assess the resident and sometimes the physician would write an order for [REDACTED]. The nurse documented the assessment in the resident's clinical assessment. -If a resident refused care, staff documented the refusal in a progress note. -The DON did not know of any issues with Resident #21's teeth. However, the DON said staff did not report every little detail to her. -The staff and the resident's DPOA had a good relationship. If the resident's DPOA wanted staff to do something about the resident's teeth, he/she would tell them.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to ensure staff provided care in a manner to prevent infection or the possibility of infection when staff did not change his/her gloves and wash his/her hands between dirty and clean tasks. The facility had a census of 52 residents. Record review of the facility's infection control policy, titled Cleaning and disinfecting resident rooms, dated November 2008, showed the following information:-Housekeeping services (example, floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled; -Use heavy-duty gloves and other personal protective equipment) for housekeeping tasks; -Heavy-duty gloves may be reused as long as the integrity of the gloves is intact and they are disinfected regularly; -Perform hand hygiene after removing gloves. Record review of the facility's Laundry policy, undated, showed the following information: -Contaminated laundry is bagged at the location where it is used and is not sorted or rinsed except in designated areas of dirty utility room and laundry area; -Contaminated laundry is placed and transported in bags that are labeled with the biohazard symbol or that are red in color. These bags are stored in the dirty laundry area until the linen can be washed. Whenever this laundry is wet and presents a reasonable likelihood that the bag will soak through or leak, the laundry is placed and transported in another bag that prevents fluid from leaking to the exterior. These bags are stored in the dirty laundry until the linen can be laundered. Record review of the facility's standard and transmission based precautions policy, dated 2007, showed the following information:-Standard precautions will be used in the care of all residents regardless of their diagnosis, or suspected or confirmed infection status. Standard precautions presume all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents; -Staff will be trained in the various aspects of standard precautions to ensure appropriate decision-making in various clinical situations; -Hand hygiene: hand hygiene refers to handwashing with soap or using alcohol-based hand rubs that do not require access to water; -Hands shall be washed with soap and water whenever visibly soiled with dirt, blood, or body fluids, or after direct or indirect contact with such, and before eating and after using the restroom; -In the absence of visible soiling of hands, alcohol-based rubs are preferred for hand hygiene; -Wash hands after removing gloves; -Gloves: wear gloves (clean, non-sterile) when you anticipate direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material; -Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean site); -Do not reuse gloves; -Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. 1. Observations on 3/2/20, at 12:37 P.M., showed the following:-Housekeeper C cleaned room [ROOM NUMBER], wearing gloves. He/she squirted toilet bowl cleaner in the toilet, and sprayed Lysol bleach. He/she cleaned the toilet with a scrub brush. -Wearing the same gloves, he/she wiped the toilet with a washcloth, picked up the toilet brush and flushed the toilet. -Wearing the same gloves, the housekeeper picked up the loose door of the housekeeping cart that fell on to the floor. -Wearing the same gloves, housekeeper C emptied the trash from the residents' trash cans and placed a new trash bag in each can. -Wearing the same gloves, the housekeeper touched the first bed's privacy curtain then swept the floor. He/she touched the first bed's privacy curtain again then touched the door knob on inside of the bathroom door and the door knob on outside of the residents' room door. Observations on 3/4/20, showed the following: -At 11:16 A.M., Housekeeper C wore gloves and scrubbed room [ROOM NUMBER]'s sink. Without removing his/her gloves, the housekeeper exited the room with soiled linens, touched the housekeeping cart and placed the soiled linens in the soiled utility room. Wearing the same gloves, Housekeeper C removed clean blankets from the clean linen cart and returned to room [ROOM NUMBER] where he/she placed the clean linens on a side table in the room. The housekeeper exited the room, wearing the same gloves and pushed the housekeeping cart to the environmental services hall; -At 11:41 A.M., while wearing gloves, Housekeeper C pushed the housekeeping cart to room [ROOM

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) NUMBER]. A comforter laid across the housekeeping cart and over the trash can attached to the cart. He/she removed a spray bottle from the cart and cleaned the mattress. The Housekeeper placed a sheet and a small blanket on the bed then placed the comforter that laid on and across the housekeeping cart onto the bed. He/she placed a pillow case on a pillow and placed it on the bed. The Housekeeper made the bed wearing the same gloves he/she used to sanitize the bed. Wearing the same gloves the housekeeper touched the television remote control, sprayed furniture polish on a cloth, cleaned inside each of the drawers and inside the closet, cleaned the mirror above the sink, emptied the trash, and cleaned the sink and countertop. Staff C placed the used cloth in a trash bag. Using a new rag, the Housekeeper wiped the bedside table, bedside table legs, opened bathroom door and touched inside of door knob. He/she cleaned the inside of toilet bowl with a toilet brush and wiped the toilet seat off with blue rag. During interview on 3/4/20, at approximately 12:00 P.M., Housekeeper C said the following: -Cleaning rooms included getting the trash first and placing clean bags in the trash can; -Bathroom cleaning included cleaning the mirror, sink and then the toilet. Then sweep and mop; -He/she worked at the facility barely a week; -He/she wore gloves and changed them every two or three rooms; -He/she changed the mop water every two or three rooms; -The supervisor trained him/her on the facility's cleaning process; -The supervisor said to always wear gloves and change in between every two or three rooms; -He/she protected the residents changing his/her gloves every two or three rooms. During an interview on 3/04/20 at 12:19 P.M., the Housekeeping Supervisor said the following: -Regular cleaning: Staff should start with the trash, then clean the bathroom, sink, mirror, and toilet; -Staff performed regular cleaning every day and deep cleaned one to two rooms per day; -The resident in room [ROOM NUMBER] discharged yesterday; -It was easier to train new staff on the cleaning process in an empty room; -He/she informed housekeeping staff of infections and instructed them to use alcohol or bleach wipes and to use a lot of Lysol; -Staff should clean mattresses with Attack if the resident had a certain type of infection; -He/she told staff to always wear gloves and change them after every room; -If staff cleaned the bathroom first they should change gloves before cleaning the rest of the room; -He/she expected housekeeping staff to change their gloves after leaving a room, before getting clean linens; -He/she expected staff to change their gloves after cleaning the bathroom and after cleaning a mattress. During an interview on 3/05/20 at 12:05 P.M., the Director of Nursing (DON) said staff should change their gloves when they were moving from one object to another or from dirty to clean. During an interview on 3/05/20 at 12:05 P.M., the administrator said the following: -The facility inserviced the staff about sanitizing in between glove changes; -The infection preventionalist and DON monitored staff to ensure they cleaned properly; -The housekeeper supervisor trained new housekeepers; -Training new housekeeping staff should include the proper use of gloves with infection control; -A clean comforter or blanket should not be placed on top of a housekeeping cart; -There was an inservice this month for housekeeping related to linen management and infection control; -Staff should change their gloves after cleaning a toilet and before touching curtains or door knobs; -Staff should change their gloves after sanitizing a bed and should not touch clean linens with the same gloves or touch a soiled utility door knob; -The housekeeping supervisor should train and work with the trainee in same room for at least a week before the trainee was on his/her own.