STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265425	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDGEWOOD MANOR HEALTH CARE CENTER	11900 JESSICA LANE RAYTOWN, MO 64138

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents' dignity by not placing a privacy bag over the catheter bag for three sampled residents (Residents #6, #20, and #37) out of 13 sampled residents. The facility census was 48 residents. 1. Record review of Resident #6's Face Sheet showed he/she was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of the resident's quarterly Minimum Data Set (MDS- a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/3/20, showed he/she: -Was alert, but had cognitive difficulty and memory problems. -Was totally dependent on staff for transfers, mobility, bathing, dressing, toileting and grooming. -Was incontinent and used a catheter for urination. Observation on 3/5/20 at 9:07 A.M., showed the resident was resting in his/her bed with his/her eyes closed. The resident's bed was in a low position and his/her catheter bag was not in a privacy bag. The resident was resting comfortably with no signs or symptoms of pain or discomfort. During an interview on 3/05/20 at 2:09 P.M., Assistant Director of Nursing (ADON) said the resident's catheter bag should always be kept in a privacy bag. -He/She went into the resident's room to place the resident's catheter bag in a privacy bag. 2. Record review of Resident #20's Face Sheet showed he/she: -Was admitted to the facility on [DATE]. -Had [DIAGNOSES REDACTED]. --Other lack of coordination. --[MEDICAL CONDITION] (paralysis) and [MEDICAL CONDITION] (slight paralysis/weakness) affecting the right side of the body following brain hemorrhage. --Generalized muscle weakness. --Retention of urine. Record review of the resident's Care Plan updated 10/2[DATE]9 showed: -The resident had an indwelling supra-pubic catheter (a sterile tube surgically inserted into the bladder through the lower abdomen to drain urine). -The resident required staff assistance with all Activities of Daily Living (ADL) tasks due to mobility issues related to [MEDICAL CONDITION] of right side, including proper placement of his/her catheter bag below the level of his/her bladder. -The resident's catheter collection bag should be stored inside a protective dignity pouch. Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Had an indwelling catheter. -Had functional limitations in range of motion on his/her upper and lower extremities on one side. -Required total assistance (full staff performance) with toilet use, including managing his/her catheter. Record review of the resident's March 2020 physician's orders [REDACTED]. Observation on 3/2/20 at 1:15 P.M. showed two Certified Nursing Assistants (CNAs) assist the resident with transferring from his/her wheelchair to bed at the resident's request. During the transfer, his/her catheter bag was hooked low on the bed frame and was not placed in a privacy bag. Observation on 3/2/20 at 2:31 P.M., 2:56 P.M., on 3/4/20 at 2:01 P.M., and on 3/5/20 at 10:50 A.M. showed the resident lying in bed watching television. His/her catheter bag was hanging low on his/her bed frame and was not in a privacy bag. 3. Record review of Resident #37's Face Sheet showed he/she: -Was admitted to the facility on [DATE]. -Had [DIAGNOSES REDACTED]. --Generalized muscle weakness. --Kidney disease. --Retention of urine. Record review of the resident's annual MDS dated [DATE] showed he/she: -Had an indwelling catheter. -Required extensive assistance from staff in all areas of ADL. Record review of the resident's Care Plan updated 2/5/20 showed he/she: -Had a Foley catheter (a tube with retaining balloon passed through the urethra into the bladder to drain urine). -Needed assistance in all areas of Activities of Daily Living (ADLs), including bed mobility, toilet use (catheter care), and positioning. Record review of the resident's March 2020 POS showed he/she had a Foley catheter due to a [DIAGNOSES REDACTED]. Observation on 3/2/20 at 9:43 A.M. showed the resident lying in bed. His/her catheter bag was hanging on the bed frame and was not in a privacy bag. Observation on 3/3/20 at 1:01 P.M. showed the resident sitting up in bed with the head of the bed inclined and watching television. His/her catheter bag was hanging on the bed frame and was not in a privacy bag. Observation at 3/4/20 at 8:32 A.M. showed the resident sitting in the bed with the head of the bed elevated. He/she was eating breakfast and watching television. His/her catheter bag was hanging on the bed frame and was not in a privacy bag. Observation on 3/4/20 at 12:21 P.M. showed the resident asleep in bed. His/her catheter bag was hanging on the bed frame and was not in a privacy bag. Observation on 3/5/20 at 10:30 A.M. showed the resident sitting up in bed with the head of the bed elevated, watching television. His/her catheter bag was hanging on the bed frame and was not in a privacy bag. 4. During an interview on 3/2/20 at 1:27 P.M., CNA F said the resident's catheter bag should be in a dignity bag. CNA E verbally agreed with CNA F. During an interview on 3/5/20 at 9:21 A.M., Licensed Practical Nurse (LPN) D said: -The resident's catheter bag should always be kept in a privacy bag. -He/She went into the resident's room to place the resident's catheter bag in a privacy bag. During an interview on 3/5/20 at 10:38 A.M., CNA C said that catheter bags should always be kept in a privacy/dignity bag. During an interview on 3/5/20 at 10:40 A.M., Registered Nurse (RN) A said: -Catheter bags should always be kept in a privacy/dignity bag, and this included when a resident was in bed. -The privacy/dignity bags were somewhat flimsy and broke or fell off easily and would often go missing. During an interview on 3/5/20 at 2:09 P.M., the ADON and Regional Nurse said privacy/dignity bags should always be used to cover catheter bags, both when residents were in bed and when they were out of bed.
F 0567 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to manage his or her financial affairs.** Based on interview and record review, the facility failed to obtain an authorization from for the facility to hold and manage resident funds for one sampled resident(Resident #31) and to implement a system to ensure receipts were retrieved by the Business Office, after the resident's family member withdrew money from the resident's fund account, for expenses. This practice potentially affected one resident out of four residents sampled for the purpose of reviewing the resident fund's process at the facility. The facility census was 48 residents. 1. Record review of the authorization forms showed the absence of a signed authorization for Resident #31. During an interview on 3/2/20 at 12:41 P.M., the Business Office Manager (BOM) said: - Resident #31 signed up for the account in September of 2019. -The resident was physically and mentally unable to sign the authorization form. -The resident's family member is the Durable Power of Attorney (DPOA- a trusted person who a resident may choose to act in that resident's place for medical care and finances if that resident became mentally incapacitated). -He/she (the BOM) forgot to have the DPOA sign the authorization form. Record review of the resident's account, showed: -The resident's relative withdrew $100 on 12/9/19. -There were not receipts in the record to show if the funds were used on behalf of the resident. During an interview on 3/2/20 at 2:40 P.M., the BOM said: -The resident's relative withdrew $100 on 12/9/19. -They did not bring back receipts to show what he/she bought for the resident. -He/she (the BOM) made the relative aware of the need for his/her office to have receipts. -To date no receipts have been returned, the relative may have forgotten.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the code status (instructions on what to do in case of cardiac or respiratory arrest) for one sampled resident (Resident #146) was transcribed to the resident's Physician order [REDACTED]. The facility census was 48 residents. 1. Record review of Resident #146's Face Sheet showed he/she was admitted to the facility on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of the resident's Hospital Discharge Record dated [DATE], showed hospital physician discussed with the resident's responsible party the resident's code status and the resident was to be a full code (a person will allow all interventions needed to get their heart started in case of cardiac or respiratory arrest). Record review of the resident's Physician's Telephone order dated [DATE], showed re-admit orders showing the resident was a Full Code. Record review of the resident's physician's orders [REDACTED]. The POS showed there was no documentation showing the resident's code status. During an interview on 3/5/20 at 9:21 A.M., Licensed Practical Nurse (LPN) D said the resident's code status was supposed to be on the resident's POS. After looking at the resident's POS dated March 2020, he/she said that he/she would correct this on the resident's current POS. During an interview on 3/05/20 at 12:10 P.M., Assistant Director of Nursing (ADON) said: -He/she typically was responsible for transcribing physician's orders [REDACTED]. -They will usually compare the POS with the resident's Medication Administration Sheet (MAR) and Treatment Administration Sheet (TAR) to ensure all of the orders match and are correct, then they compare it to the last months MAR/TAR and POS. -Any new orders that are written are added to the current POS and they send the telephone orders to the pharmacy so they can be added to the following months POS, MAR, and TAR. -For the last two months, he/she had not been able to follow up and the responsibility was delegated to other nurses. -After looking at the resident's Physician's Telephone Orders and POS's, he/she said that the print out of the resident's current POS was completed and it was missed.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to do the following: maintain the fan in Resident #33's room free of a heavy buildup of dust; maintain the backing support of the shower chair free of large rips, failed to maintain the shower mat in the 500 Hall shower room free of rips and tears which caused it to be not easily cleanable; failed to maintain the brakes of the wheelchairs that belonged to Residents #45 and #25 in working order; and failed to maintain the restroom ceiling vent in resident room [ROOM NUMBER] free of a heavy buildup of dust. This practice potentially affected at least 40 residents who used or resided in those areas. The facility census was 48 residents. 1. Observations with the Environmental Services Director and the Maintenance Director on 3/3/20, showed the following: - At 8:58 A.M., there was a heavy buildup of dust on the fan in Resident #33's room. - At 9:00 A.M., Resident #33 said facility staff had not cleaned his/her fan. - At 9:00 A.M., The Environmental Services Director said the fan absolutely needed to be cleaned. - At 9:18 A.M., there was a 2 foot (ft.) long rip in the back support of the 500 Hall shower chair. - At 9:20 A.M., Certified Nurse's Assistant (CNA) A said that shower chair has been like that for about one month. - At 9:21 A.M., there were five ripped areas of 1 inch (in.) or more in the shower mat, which made it (the shower mat) not easily cleanable. - At 9:48 A.M., the left brake of Resident #45's wheelchair did not hold the left wheel firmly, when it was pressed down. - At 9:49 A.M., the Maintenance Director confirmed the observation of the left brake not holding the left wheel firmly. - At 11:24 A.M., there was a heavy buildup of dust on the ceiling vent in resident room [ROOM NUMBER]. Observation on 3/5/20 at 9:44 A.M., with CNA B of the left brake of Resident #25's wheelchair showed that the brake did not firmly hold the left wheel in place when engaged. During an interview on 3/5/20 at 9:45 A.M., CNA B acknowledged the observation and said he/she would report it to the Maintenance Director. Record review of the maintenance request book, showed that from [DATE] through 3/5/20, there was nothing written about wheelchairs in there. During an interview on 3/5/20 at 9:05 A.M., CNA A said: -He/she had not used the shower mat in the past and did not know about the tears within the shower mat. -He/she would report damaged equipment to the Maintenance Director so the Maintenance Director could order a replacement for the backing of the shower chair, because the Maintenance Director was in charge of ordering new or replacement equipment. During an interview on 3/5/20 at 9:18 A.M., the Assistant Director of Nursing (ADON) said the CNAs should check the brakes when the clean the wheelchairs at night and report to the Maintenance Director if the brakes were not working at the time. During an interview on 3/5/20 at 9:23 A.M., the Maintenance Supervisor said the damaged shower chair should have been reported to him/her by the nursing staff. During an interview on 3/5/20 at 9:24 A.M., the Maintenance Director said it is both the job of nursing staff and Maintenance staff to check the wheelchairs, and once they find something, they should write that in the maintenance book.
F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to keep three sampled residents (Residents #39, #21, and #9), free from verbal abuse from a facility employee when Resident #39 had felt bad' about him/herself, Resident #21 had felt worthless about him/herself and had thrown up and Resident #9 felt bad about him/herself after the verbal abuse from facility staff out of three sampled residents. The facility census was 48 residents. Record review of the facility's Abuse Policy dated 5/2019 showed: -The facility policy was to prohibit resident abuse where there was cause to believe a resident' mental health or welfare had been adversely affected by the abuse caused by another person. -Verbal was the use of oral, written or gestured language that included disparaging or derogatory terms within the resident's hearing distance. -The definition of abuse meant to inappropriately treat or exploit a resident including humiliation, harassment, threats, deprivation or intimidation. -All residents were to be immediately protected from abuse. -Allegations involving facility staff would necessitate suspension without pay pending the investigation and termination if the allegations were substantiated. 1. Record review of Resident #39's Facility Face Sheet showed he/she was admitted on [DATE] with the following Diagnoses: [REDACTED]. -History of shortness of breath. Record review of the resident's Nursing Care Plan initiated on 8/8/19 showed: -The resident had issues with mobility and required assistance with turning and repositioning. -He/she had periods of incontinence and required assistance with elimination needs and incontinence care. -The resident's linens were to be kept clean and dry. -The facility staff was to assist with positioning, dressing, bathing and transfers. -He/she was to be checked for incontinence every two hours and as needed during the night. -The facility staff was to provide absorbent products as needed for dignity. Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 2/4/20 showed he/she: -Was cognitively intact. -Had no negative behaviors. -Required supervision to total dependence of one to two facility staff for bed mobility, transfers, daily hygiene, bathing, toileting and dressing. -Was incontinent of both bowel and bladder at times. During an interview on 3/13/20 at 2:15 P.M., the resident said: -When he/she turned his/her call light on, two Certified Nurses Aide's (CNA) came into his/her room early the morning of 3/13/20. -He/she asked to be changed as his/her brief was wet. -CNA G told the resident that he/she and CNA H could not change him/her for an hour because that was when they would do rounds. -CNA H did not say anything. -When the CNA's came back to his/her room an hour later to change his/her brief, CNA G asked the resident to help by rolling over so they could change him/her. -The resident stated that he/she could not help a lot but would try. -At that time, CNA G said, You need to move your white fat ass and help us! -CNA H said nothing but just continued to help CNA G to roll the resident over to his/her side. -The resident also felt that CNA G was very rough with him/her when turning him/her but said he/she was not injured. -The resident felt bad about himself/herself after the interaction with CNA G. 2. Record review of Resident #21's Facility Face Sheet showed he/she was admitted on [DATE] with a [DIAGNOSES REDACTED]. Record review of the resident's Nursing Care Plan initiated 8/1/19 showed: -The resident had issues with elimination, requiring assistance with toileting. -The facility staff was to check the resident for incontinence every two hours and as needed during the night. -The facility staff was to provide absorbent

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) products as needed for dignity. -The resident had issues with mobility and performing daily needed self-care. -He/she needed to be frequently checked for proper positioning, ensuring that he/she was comfortable due to the resident's inability to adequately use his/her extremities. Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Was cognitively intact. -Had no negative behaviors. -Required supervision to total dependence of one to two facility staff for bed mobility, transfers, daily hygiene, bathing, toileting and dressing. -Was incontinent of both bowel and bladder at times. During an interview on 3/13/20 at 2:45 P.M., the resident said: -Two CNA's came into his/her room early the morning of 3/13/20 to reposition him/her. -CNA G jerked on him/her to get him/her turned and called the resident a white MF'er. -The resident said that it made him/her feel worthless to be treated that way. -He asked the Activity Coordinator (AC) to sit with him/her at breakfast because he/she was afraid CNA G might come back and he/she was afraid of CNA G. -CNA H said nothing while in his/her room. 3. Record review of Resident #9's Facility Face Sheet showed he/she was admitted on [DATE] with a [DIAGNOSES REDACTED]. -[MEDICAL CONDITION]. Record review of the resident's Nursing Care Plan initiated on 9/16/20 showed: -The resident was to be observed for any [MEDICAL CONDITION] activity throughout all shifts. -The facility staff was to keep the resident safe. -The facility staff was the check the resident for incontinence every two hours and as needed during the night. -The facility staff was to provide absorbent products as needed for dignity. -The resident had issues with mobility and performing daily needed self-care. -The facility staff was to provide absorbent products as needed for dignity. -The resident had issues with mobility and performing daily needed self-care. -He/she needed to be frequently checked for proper positioning, ensuring that he/she was comfortable due to the resident's inability to adequately use his/her extremities. During an interview on [DATE] at 1:20 P.M., the resident said: -CNA G and CNA H pulled him/her up in bed and tossed him/her on the mechanical lift sling. -CNA G was very rude and said not to tell anyone. -CNA H did not say anything but seemed to be doing what CNA G said to do. -CNA H was very quiet. 4. During an interview on 3/13/20 at 10:00 A.M., the Director of Nursing (DON) said: -CNA A came to the DON stating that Resident #39 wanted to speak with him/her and was upset. -The DON went to see the resident who reported that CNA G, a night shift CNA had been verbally abusive to him/her earlier in the morning of 3/13/20. -Around the same time, the AC was helping to pass breakfast trays when Resident #21 told the AC that he/she was afraid to be alone, asking the AC to stay with him/her as CNA G had been mean to him/her earlier in the morning of 8/13/20 and he/she did not want to be alone. -As the DON and Administrator began interviewing other residents, they found Resident #9 had a similar experience with the same CNA earlier in the morning of 3/13/20. During an interview on 3/13/20 at 11:00 A.M., the Administrator said: -Resident #39 told him/her, CNA G came in to answer my call light and when I told CNA G I was wet, CNA G told me I had to wait an hour until their rounds before he/she would change me. Then when the CNA G came back in early this morning, he/she called me a fat ass for not helping enough to turn myself. -Resident #39 described CNA G to the Administrator. -Resident #39 stated CNA G was rough when turning him/her, but he/she was not injured. -When the Administrator interviewed Resident #21, he/she stated that he/she had issues with CNA G being mean to him/her, it made him/her feel bad about himself/herself and it made him/her throw up. Attempts were made to contact CNA G by phone at 11:15 A.M., 11:45 A.M., 1:00 P.M., and 2:30 P.M. on 3/13/20 with messages left each time with no return call. Attempts were made to contact CNA H by phone at 11:20 A.M., 11:50 A.M., 1:15 P.M., and 2:45 P.M., on 3/13/20 with messages left each time and no return call. During an interview on [DATE] at 10:00 A.M., the Administrator said: -He/she had terminated CNA G. -He/she felt that CNA G was intimidating CNA H and that CNA G was the abusive employee. During an interview on [DATE] at 1:30 P.M., the AC said: -He/she took food into Resident #21. -Resident #21 asked him/her if he/she would stay with him/her. -Resident #21 said CNA G had been mean to him/her, and did not want to be alone and felt scared. -The AC stayed with the resident until he/she felt safe and then he/she went and reported the issue to the DON. During an interview on [DATE] at 2:00 P.M., CNA A said: -On 3/13/20 when he/she was coming into work and CNA G was clocking out, CNA G confronted CNA A. -CNA G said to CNA A, I should start working the dayshift so I can show you [***] es how it's done! -CNA A stated to CNA G the comment greatly offended him/her and it was inappropriate. -CNA G replied to CNA A he/she did not mean to offend CNA A, he/she just talked like that because he/she was ghetto. During an interview on [DATE] at 2:30 P.M., the Administrator and DON said they understood they had responsibility for keeping the residents free from all types of abuse at all times. Attempts were made to contact CNA G by phone on [DATE] at 9:00 A.M., 10:30 A.M., 12:30 P.M., and 1:45 P.M., with messages left each time and no return call. Attempts were made to contact CNA H by phone on [DATE] at 9:05 A.M., 10:35 A.M., 12:35 P.M., and 12:40 P.M., and 1:55 P.M., P.M., on [DATE] with messages left each time and one return call. When CNA H returned the telephone call on [DATE] at 12:35 P.M., he/she left a message stating he/she did not know why anyone needed to speak with him/her. He/she was called back at 12:40 P.M., on [DATE] and a message was left for him/her informing him/her that he/she was a witness to three separate incidents and he/she was needed to give his/her recount of the incidents. No return calls were received from CNA H. Record review of the Facility Investigation date 3/18/20 showed: -CNA G and CNA H were both notified on 3/13/20 that they were suspended pending investigation. -All three sampled residents were assessed by the nursing staff on the morning of 3/13/20 and none showed any physical injuries. -All three sampled residents' physicians were notified on the morning of 3/13/20. -The facility made the determination after the conclusion of their investigation, CNA G would be terminated and CNA H would be reinstated as all sampled residents described CNA G as being the abusive staff member. -All three sampled residents showed their Nursing Care Plans were being followed as written. -The facility determined that the incidents could not have been prevented as CNA G had been educated regarding Abuse and Neglect and Resident Rights facility policies upon hire. -The Administrator notified the CNA Registry regarding the abuse allegations towards CNA G. -CNA H was re-educated by the DON regarding the Abuse and Neglect policy. A certified letter was sent to CNA G on 3/18/20. As of 3/24/20, no return call had been received by CNA G. MO 876
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the care plans were comprehensive and updated to reflect the current status with interventions needed for one sampled resident (Resident #1) with and indwelling catheter (Foley catheter, a sterile tube that is inserted into the bladder to drain urine) out of 13 sampled residents. The facility census was 48 residents. 1. Record review of Resident #1's Admission Face Sheet showed he/she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunnelling). -[MEDICAL CONDITION] (gradual loss of kidney function). Record review of the resident's Admission Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated [DATE] showed he/she: -Was alert, and had no cognitive difficulty and memory problems. -Was totally dependent on staff for transfers, mobility, bathing, dressing, toileting and grooming. -Was incontinent at times and used a Foley catheter for urination. -Had a Stage IV pressure ulcer upon admission. Record review of the resident's undated Baseline Care Plan, Under special Care instruction showed: -The resident had a Foley catheter. -The Foley catheter size was an 18 French (fr, size of the tube) with a 30 centimeters (cc) balloon (the amount fluid needed to inflate the balloon to hold catheter in place). -Had a check mark by to provide supportive devices such as a catheter. -No instruction on care of the Foley catheter. -Did not have check mark in the box to follow protocol to care for the items marked in special care instructions. Record review of the resident's Bowel and Bladder Care Plan dated 12/5/19 showed: -The resident required a Foley catheter for wound healing. -Staff were to provide assistance with hygiene, emptying catheter bag as well as clothes management. -Care staff and nursing staff were to observe the resident's urinary output for signs of infections, such as dark color, strong odor, heavy sediment, and were to update the physician as needed. -No interventions related to the type of Foley catheter or the size of the resident catheter and how the facility staff are to care for his/her catheter. Record review of the resident's care plans dated 12/5/19 showed he/she did not have a care plan for his/her Foley catheter. Record review of the resident's progress note dated 12/8/19 showed: -The resident's Foley catheter had been changed due to it not draining and the resident's complaints of burning. -New order from the resident's physician's Nurse Practitioner (NP) for a Foley catheter size 16 fr with 10 cc balloon. Record review of the resident's Bowel and Bladder Care Plan updated on 12/8/19 showed: -Urinalysis (UA) with Culture and Sensitivity (urine sample checking for infections) if indicated. -No documentation related to change in catheter size. Record review of the resident's Treatment Administration Record (TAR) dated 12/1/19 to 12/31/19 showed: -Foley catheter care every shift. -Foley catheter size of an 18 fr with a 30 cc balloon and to be change monthly for leakage. -Change Foley catheter collection bag weekly on Wednesday. Record review of the resident's nurses progress notes dated 2/18/20 showed he/she: -Had been sent to hospital for

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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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) evaluation and treatment on 2/17/20. -Returned with treatment for [REDACTED]. Record review of the resident's physician's orders [REDACTED]. -Foley catheter size of an 16 fr with a 10 cc balloon and to be change monthly for leakage. -Change Foley catheter collection bag weekly on Wednesday. Observation on 3/2/20 at 2:00 P.M. of the resident's catheter site showed: -No redness noted. -The skin was sticking together from the cream used for his/her groin irritation per Registered Nurse (RN) A. -The catheter bag had been placed in a privacy bag and was hanging on the lower left bedrail. During an interview on 3/5/20 at 10:31 A.M., Certified Nursing Assistant (CNA) C said: -CNAs review care plan interventions; the care plans are available to CNAs in the care plan books. -Care plans have handwritten updates as they are needed, then all of the changes are incorporated into an updated (typed) document every six months or sometimes more often if needed. Observation on 3/5/20 at 11:15 A.M. of the resident's Foley catheter care with Assistant Director of Nursing (ADON) showed the resident had a Foley catheter and the size on the tube showed it was a 16 fr with a balloon could hold from 5 cc to 15 cc of fluid. During an interview on 3/5/20 at 12:30 P.M., the MDS Coordinator said: -He/she relied on gathering information on resident needs and changes from nursing staff and therapy at morning meetings every Monday through Friday at 9:15 A.M. -Care plans should be accurate, comprehensive, and reflect resident needs and conditions, and include interventions that are specific to resident needs. During an interview 03/05/20 at 1:43 P.M., ADON and Regional Nurse said: -It was expected care plans be comprehensive, reflect current conditions of the resident and the needs of residents. -Would expect to had a comprehensive care plan for resident's with a Foley catheter.
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 equipment for maintaining or improving range of motion was available for one sampled resident (Resident #20) out of 13 sampled residents. The facility census was 48 residents. Record review of Resident #20's Face Sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. -Other lack of coordination. -[MEDICAL CONDITION] (paralysis) and [MEDICAL CONDITION] (slight paralysis/weakness) affecting the right side of the body following brain hemorrhage. -Generalized muscle weakness. Record review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning) dated 1/8/20 showed he/she had functional limitations in range of motion on his/her upper and lower extremities on one side. Record review of the resident's February 2020 physician's orders [REDACTED]. Record review of OT progress notes dated 2/18/20 showed: -Resident received OT services through 2/18/20 due to right side [MEDICAL CONDITION]. -Staff training was completed to carry on the following orthotic program: resident will tolerate right resting hand/wrist orthotic for 4 - 6 hours with good joint/skin integrity. Record review of the resident's Care Plan dated 2/19/20 showed: -The resident had range of motion and mobility deficiencies related to [MEDICAL CONDITION] of his/her right side. -Discontinue skilled OT. -Continue splinting order. Record review of the resident's February 2020 Treatment Administration Record (TAR) showed no documentation by the facility staff related to the resident's orthotic program. Record review of the resident's March 2020 POS showed: -The resident's splinting order to continue the resident's orthotic program was not transcribed to the current POS as previously ordered by the resident's physician. -No documentation by the resident's physician to discontinue the splinting order/orthotic program. Record review of the resident's March 2020 TAR showed no documentation by the facility staff related to the resident's orthotic program. Record review of the resident's nursing notes dated 2/19/20 through 3/5/20 showed no documentation by the facility staff that the resident was assisted with his/her orthotic device. Observation on 3/2/20 showed: -9:20 A.M.: The resident entered his/her room with staff pushing his/her wheelchair. No hand splint was observed in the resident's hand or anywhere in the resident's room. -9:29 A.M.: The resident was sitting in his/her wheelchair in the common area of the facility. No hand splint was observed in the resident's hand. -1:15 P.M.: The resident was sitting in his/her wheelchair in his/her room waiting for staff to assist him/her with getting into bed. No hand splint was observed in the resident's hand or anywhere in the resident's room. -2:09 P.M.: The resident was transferred into his/her bed by two Certified Nursing Assistants (CNAs). Before, during, and after the transfer, no hand splint was observed in the resident's hand or anywhere in the resident's room. -2:56 P.M.: The resident was lying in his/her bed. No hand splint was observed in the resident's hand or anywhere in the resident's room. Observation on 3/3/20 showed: -8:40 A.M.: The resident was sitting in his/her wheelchair in the common area of the facility near the doors where the sun was shining in. He/she showed the Activities Director (AD) the fingernails of his/her right hand, which had a contracture (a condition of shortening and hardening of the muscles, characterized by flexion and fixation). The AD reminded the resident that they had just trimmed his/her fingernails to keep them from injuring the palm of his/her hand due to the contracture. No injury or issue was observed. No hand splint was observed in the resident's hand. -10:58 A.M.: The resident was observed going outside with other residents onto a closed patio with assistance of staff pushing his/her wheelchair. No hand splint was observed in the resident's hand. Observation on 3/4/20 showed: -2:01 P.M.: The resident was lying in bed watching television. No hand splint was observed in the resident's hand or anywhere in the resident's room. Observation on 3/5/20 showed: -8:49 A.M.: The resident was observed sitting in his/her wheelchair in the common area of the facility. No hand splint was observed in the resident's hand. -10:50 A.M.: The resident was lying in bed watching television. No hand splint was observed in the resident's hand or anywhere in the resident's room. During an interview on 3/5/20 at 8:49 A.M., the resident nodded his/her head up and down to indicate yes when asked if he/she had a splint or sponge to put into his/her right hand to help keep it from being a tight fist. The resident shook his/her head left and right to indicate no when asked if he/she still used the splint. The resident also shook his head left and right to indicate no when asked if he/she would let staff assist him/her with using the splint. During an interview on 3/5/20 at 10:31 A.M., CNA C said: -The resident has a hand splint and he/she had seen it a couple of times, but not recently. -He/she knew the resident did not like to wear it. -He/she did not know where it was kept or if it was still available. -If a resident had a therapy or physician's orders [REDACTED]. During an interview on 3/5/20 at 10:34 A.M., Registered Nurse (RN) A said: -The resident did have a device for his/her hand contracture that was fitted to him/her by therapy. -He/she had not seen the resident wear the splint for a while, but could not recall how long it had been. -About a month ago, he/she remembered the resident had the splint for his/her hand but could not find it. He/she talked to the therapy department at that time to see if it was in their area but it was not. -The resident had moved from one area of the facility to his/her current room a couple of months ago and sometimes items would get misplaced during moves. -The splint was blue on the outside with a foam piece that fit into the resident's hand. During an interview on 3/5/20 at 10:37 A.M., CNA C said: -He/she had found the splint in the resident's room inside a drawer of a small dresser where the resident's television sat. -If there was a physician's orders [REDACTED]. -If the resident refused to use it, staff should document that. During an interview on 3/5/20 at 10:59 A.M., the Director of Rehabilitation said: -Information related to residents' therapy needs was communicated between the therapy department and facility nursing staff during morning meetings each Monday through Friday. -The resident's splint was a resting splint, which meant that it was used to prevent further contracture or deformity. It was not a functional splint, which would be used to regain functional use of the hand. -The resident's splint should be used at night while the resident was resting with less activity to interrupt wearing it. He/she would communicate this to nursing staff to ensure this was understood. -If ongoing use of the splint was ordered by the Registered Occupational Therapist (OTR) and the physician, it should be followed by facility nursing staff. -Staff should document the use or refusal to use the splint and communicate issues with the resident using the splint to the therapy department as needed. During an interview on 3/5/20 at 12:10 P.M., the Assistant Director of Nursing (ADON) said: -He/she typically competed the transcription of physician's orders [REDACTED]. -This responsibility had been delegated to another nurse for the last two months. -The new POS should be checked against the current POS to ensure that they match, and any new orders should also added. -When the new month's completed POS was sent from the pharmacy, it should be re-checked to ensure accuracy. During an interview on 3/5/20 at 1:55 P.M., RN A said: -He/she reviewed the March 2020 Medication Administration Record [REDACTED]. During an interview on 3/5/20 at 2:09 P.M., the ADON and the Regional Nurse said: -physician's orders [REDACTED]. by the ADON or the nurse delegated to complete that task. -If a resident had a physician's orders [REDACTED]. -Use of the hand splint for ongoing maintenance by nursing staff should be documented on the TAR. -If the resident refused to use the splint, this should be circled on the TAR and a description documented on the back of the TAR and in nursing notes.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate**

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	265425	A. BUILDING _____ B. WING _____	03/16/2020

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) **supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a safe transfer for two sampled residents (Residents #38 and #15), and to ensure the accuracy of assessments and care planning related to safe transfer for one sampled resident (Resident #15) out of 13 sampled residents. The facility census was 48 residents. 1. Record review of Resident #38's Face Sheet showed he/she was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 2/4/19, showed he/she: -Was cognitively intact. -Needed limited assistance with bathing, dressing, toileting, and transferring. -Was not stable to transfer from surface to surface without assistance. -Used a wheelchair to mobilize. Record review of the resident's Care Plan, updated 1/6/20, showed he/she was at risk for falls related to unsteady balance and medications. It showed the resident is non-ambulatory and had falls with and without injury. Interventions showed the resident was not to transfer without assistance. The care plan did not show how the resident transferred with assistance. Observation on 3/03/20 at 9:21 A.M., showed the resident was sitting up in bed. Certified Nursing Assistant (CNA) D and CNA B were already in the resident's room after performing incontinence care and both were wearing gloves. CNA D and CNA B lowered the resident's bed and assisted him/her to a sitting position on the side of his/her bed. There was a stand up mechanical lift in the resident's room that the CNAs pulled in front of the resident. The CNAs assisted the resident to place his/her feet on the footpad. The CNAs then attached the sling, which went behind the resident's back and under his/her arms, to the lift. There was a safety belt that the CNAs did not secure-they did not attach the belt closure and left the belt loosely hanging. CNA D controlled the lift while CNA B assisted with positioning the resident in his/her wheelchair. CNA D moved the lift out of the room while CNA B put the footrests on the resident's wheelchair and placed him/her feet on them. CNA D gloved and made the residents bed. CNA B then put a new bag in the resident's trash then washed his/her hands. During an interview on 3/03/20 at 9:29 A.M., CNA D said: -They were supposed to put the safety belt around the waist of the resident when using stand up lift. -They should fasten the belt to ensure the resident's safety and their safety, but he/she forgot to fasten it. 2. Record review of Resident #15's Face Sheet showed he/she was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. Record review of the resident's quarterly MDS dated [DATE] and 12/31/19 showed he/she: -Was cognitively intact. -Required physical assistance of one person to transfer from one surface to another. -Was not stable to transfer from surface to surface without staff assistance. -Had impairment in upper extremity (shoulder, elbow, wrist, or hand) movement on one side. -Had no impairment in lower extremity (hip, knee, ankle, or foot) movement. -Used a wheelchair for mobility. Record review of the resident's care plan dated 2/10/20 showed no documentation related to the resident's lower extremity weakness or the need to use a mechanical lift (a mechanism that lifts and transfers a person from one place to another using a sling secured to a hydraulic lift) for transfers. Observation on 3/2/20 at 8:43 A.M. showed: -The resident was sitting on the side of the bed with his/her feet on the floor. -CNA E was in the room wearing gloves, and was preparing to use the mechanical sit-to-stand lift to assist the resident with transferring from his/her bed to the wheelchair. -No other staff was in the resident's room. -CNA E moved the lift in front of the resident and placed the sling around the resident's back and under his/her arms, then hooked the loops on the sling to the rings on the lift. -CNA E asked the resident if the sling was comfortable and felt secure, and the resident said yes. -CNA E assisted the resident with getting his/her feet in the right place on the footpad of the lift. -CNA E did not fasten the safety belt of the sling around the resident. -With the resident holding onto the hand bars on the lift, CNA E used the remote control of the lift to slowly lift the resident into a standing position. -The sling appeared to pull light under the resident's armpits, but he/she said it felt fine. -CNA E rotated the resident in the lift clockwise and pushed the lift forward to position the resident over the seat of the wheelchair. -CNA E walked behind the resident to ensure that he/she was placed over the seat of the wheelchair, and made sure the wheels were in a locked position. -CNA E then walked back to the front side of the lift (out of arm's reach of the resident) and lowered the resident into the seat of the wheelchair. -CNA E unhooked the sling from the lift and removed the sling from behind the resident. Observation of 3/4/20 at 8:54 A.M. showed: -CNA E was in the resident's room, wearing gloves, with the mechanical sit-to-stand lift near the resident's bed. -No other staff was in the resident's room. -The resident was sitting on the side of the bed with his/her feet on the floor. -CNA E moved the lift in front of the resident and placed the sling around the resident's back and under his/her arms, then hooked the loops on the sling to the rings on the lift. -CNA E assisted the resident with getting his/her feet in the right place on the footpad of the lift. -CNA E asked the resident if the sling felt comfortable and the resident said yes. -CNA E did not fasten the safety belt of the sling around the resident. -With the resident holding onto the hand bars on the lift, CNA E used the remote control of the lift to slowly lift the resident off of the bed to a standing position. -CNA E rotated the lift clockwise and pushed the lift forward to position the resident over the seat of the wheelchair. -CNA E checked the placement of the resident over the seat of the wheelchair and the wheelchair wheels appeared to be in a locked position. -CNA E then stepped back to the front of the lift (out of arm's reach of the resident) and lowered the resident into the seat of the wheelchair. -CNA E unhooked the sling from the lift and removed the sling from behind the resident. During an interview on 3/5/20 at 8:16 A.M., the resident said: -Staff have used the mechanical sit-to-stand lift to assist him/her with transfers since he/she has lived at this facility. -He/she has felt comfortable (no pain) when the lift was used unless staff left her in the standing position for too long. That had rarely happened and he/she told staff and they lowered her down to a surface. He/she could not remember when this had happened or how many times. -He/she felt secure when the lift was used and had never been afraid of slipping out of the sling. 3. During an interview on 3/5/20 at 8:34 A.M., CNA C said: -If a resident uses a mechanical lift, that should be documented in the care plan. -The resident has used a mechanical sit-to-stand lift since he/she has worked at the facility, but that had only been a few weeks. -There should always be two staff present to assist a resident with any transfers using a mechanical lift. -Staff do not always ensure that two staff are present when transferring residents using the mechanical sit-to-stand lift. -New CNAs are trained to use mechanical lifts by watching other staff complete mechanical lift transfers a couple of times. During an interview on 3/5/20 at 9:28 A.M., the Assistant Director of Nursing (ADON) said: -If a resident uses a mechanical lift, that should be documented in the care plan. -There should always be two staff present to assist a resident with any transfers using a mechanical lift. During an interview on 3/05/20 at 11:45 A.M., Licensed Practical Nurse (LPN) D said when transferring a resident with a sit to stand lift, they should fasten the safety belt so the resident is more safely transferred. During an interview on 3/5/20 at 12:39 P.M., the MDS Coordinator said: -If a resident used mechanical lift for transfers most of the time, the MDS should show that the resident needed assistance from at least two staff during transfers. -If a resident used mechanical lift for transfers most of the time, that information and interventions specific to the resident's needs should be care planned. -If a resident had lower extremity impairment, this should be reflected in the MDS assessment and the care plan. -Information related to the functional needs of a resident was gathered at care plan meetings. -Information related to resident care was gathered at care plan meetings and also communicated among the nursing department, therapy department, other facility department leaders, and the MDS Coordinator at morning meetings every Monday through Friday. -Any change in resident condition or support needs should be communicated by nursing or therapy to the MDS Coordinator in morning meetings. -MDS assessments should be comprehensive, accurate, and reflect the current needs and conditions of residents. -Care plans should be comprehensive, accurate, reflect the current needs and conditions of the resident, and include specific supports and interventions needed by that resident. During an interview on 3/5/20 at 2:09 P.M., the ADON and Regional Nurse said: -There should always be two nursing staff present to assist a resident with any transfer using a mechanical lift. -The safety belt of the mechanical lift sling should always be fastened prior to completing the transfer for the safety of the resident. -MDS assessments should be comprehensive, accurate, and reflect the current needs and conditions of residents. -Care plans should be comprehensive, accurate, reflect the current needs and conditions of the resident, and include specific supports and interventions needed by that resident.
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 failed to obtain a physician's order for a resident to self-administrator his/her medications; to assess the resident ability to be able to self-administer medication and to

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) ensure to update the resident respiratory care plan to reflect current health status for one sampled resident (Resident #33) out of 13 sampled resident. The facility census was 48 residents. 1. Record review of Resident #33 Admission Face Sheet showed he/she was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. -[MEDICAL CONDITION] (disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body). -The resident was his/her own responsible person. Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool required to be completed by facility staff for care planning) dated 2/3/20 showed he/she: -Had [DIAGNOSES REDACTED]. -He/she was able to make his/her needs known. -Did not indicate the resident had [MED]gen while resident. Record review of the resident's [MEDICAL CONDITION] Care Plan dated 8/7/19 showed: -The resident had the potential at risk complication respiratory distress related to [MEDICAL CONDITION]. -He/she required [MED]gen as ordered. -Nursing staff were to provide medication as physician's ordered. -Nursing staff were to monitor the resident's lung sounds and [MED]gen saturation via pulse oximetry as ordered by the resident physician's. -Did not indicate the resident had nebulizer breathing treatment as needed for [MEDICAL CONDITION]. -Did not indicate the resident may self-administration his/her nebulizer treatment or nursing assessment for the resident's ability to self-administer medication. -Did not indicate the resident may keep nebulizer medication at his/her bedside. Record review of the resident's Physician's Progress Note dated [DATE] showed; -The resident had complaint of cough, chest congestion and night sweats for the past several days. -The physician's assessment of the resident showed he/she had [MEDICAL CONDITION] (lung) congestion and coarse crackles in the lungs. -The resident plan included: -Resident had lab work ordered and a chest x-ray. -Nursing staff were to continue to monitor the resident's [MEDICAL CONDITION] status. Record review of the resident's Physician's Order Sheet (POS) dated [DATE] to 3/31/20 showed: -A physician's order for the resident to be given [MEDICATION NAME] (breathing treatment medication, two medicines work together to help open the airways in the lungs) 2.5-0.5 milligrams per 3 milliliters (mg/ml) inhale, one vial via nebulizer every six hours as needed for [MEDICAL CONDITION]. -No physician's order for the resident to provide his/her own breathing treatment or to keep medication in his/her room. Record review of the resident's medical record showed no documentation of the resident's ability to self-administer medication. During observation and interview on 3/02/20 at 3:23 P.M., the resident said: -He/she has had respiratory issue of a cold for last five days. -The facility nursing staff had been monitoring his/her lungs sounds. -On [DATE] he/she had wheezing in his/her lungs. -He/She had been performing his/her own breathing treatment. -Observation of his/her nebulizer machine with tubing attached was located on the sink counter in the resident's bathroom. Observation and interview 3/3/20 at 10:40 A.M. of the resident room showed: -Observation of his/her nebulizer machine with tubing attached located on the sink counter in the resident's bathroom. -He/she had one unopened vial of [MEDICATION NAME] medication next to the nebulizer machine. -The resident said normally the nursing staff setup the breathing treatment, but since he/she had been having shortness of breath the nursing staff had left one vial in his/her room just in case he/she had shortness of breath during the night, then the resident could provide his/her own treatment right away. Observation 3/4/20 at 12:45 P.M. of the resident room showed: -His/her nebulizer machine, tubing and mask on the sink counter in the resident's bathroom. -He/she had one unopened vial of [MEDICATION NAME] medication next to the nebulizer machine. During an interview on 3/5/20 at 12:55 P.M., Registered Nurse (RN) A said: -He/She was not aware of any resident providing their own breathing treatment at this time. -The resident had an as needed physician order for [REDACTED].M., Regional Nurse, Assistant Director of Nursing (ADON) said: -They were not aware of any resident at this time providing their own administration of medication. -Would expect to for the resident to have a physician's order to keep medication at bedside and to self-administer any type of medication. -Would expect nursing staff to ensure to have a physician's order for the resident to self-administer of breathing treatments if required. -Would not be normal nursing practice for the resident to provide own breathing treatment without nursing monitoring. -The facility nursing staff need to be able to assess the resident's lung sounds before and after a breathing treatment. -Would expect to see detail comprehensive care plan related breathing treatment and [MEDICAL CONDITION].
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, interview and record review, the facility failed to ensure the medication refrigerator temperature was monitored and maintained within the appropriate range for the refrigerated medications and vaccines. The refrigerator temperature was 52 degrees Fahrenheit (F) Affecting a total of 85 medications including [MED], vaccine, antipsychotics and anti-anxiety medications. Two sampled residents (Resident #1 and #2) had been given medication out of that refrigerator that day. There were 13 sampled and 8 supplemental residents. The facility census was 48 residents. Record review of the manufacturers package insert for [MEDICATION NAME] AC (used to increase urine concentration and decrease urine production) revised in July 2007 showed: -Store in refrigerator between 36 F and 46 F. Record review of the Manufacturers package insert from AbbVie Inc revised in August 2017 showed: -Store [MED] ([MEDICATION NAME] used to stimulate the appetite and decrease nausea) in a cool place such as in a refrigerator, at a temperature between 46 F and 59F . -Do not freeze [MEDICATION NAME] capsules. Record review of Omnicare 2016 [MED] storage recommendation showed: -Unopened [MED] should be stored in the refrigerator between 36F and 46 F. Record review of Manufacturers package insert for [MEDICATION NAME] (an antipsychotic. It is used to treat [MEDICAL CONDITIONS] disorder, and irritability associated with autism) revised in July 2007 showed: -The entire dose pack should be stored in the refrigerator between 36and 46F and protected from light. -If refrigeration is unavailable, [MEDICATION NAME] can be stored at temperatures not exceeding 77F for no more than 7 days prior to administration. -Do not expose un-refrigerated product to temperatures above 77F. Record review of the Center for Disease Control and Prevention (CDC) storage and handing of Vaccine reviewed April 15, 2019 showed: -Store all other routinely recommended vaccines in a refrigerator between 35F and 46F. -The desired average refrigerator vaccine storage temperature is 40F. -Exposure to temperatures outside these ranges may result in reduced vaccine potency and increased risk of vaccine-preventable diseases. -The vaccine must be stored in a refrigerator which is monitored daily to ensure the correct temperature of 35F and 46F is maintained. 1. Record review of Resident #1's face sheet showed he/she had been admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. -Diabetic [MEDICAL CONDITION] (gradual loss of the kidneys ability to filter blood like they should, which can cause wastes to build up in your body). Record review of the resident's Admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) dated [DATE] showed he/she: -Was alert and had no cognitive difficulty or memory problems. -Had received seven injections during assessment period. -Had a [DIAGNOSES REDACTED]. [REDACTED].M. during medication pass showed Licensed Practical Nurse (LPN) B: -Checked the resident's order of [MEDICATION NAME] AC, 4 mcg/ml inject 0.5 mg sub-q every 12 hours for [DIAGNOSES REDACTED]. --The medication was supposed to be stored in the refrigerator not the medication cart. -Injected the medication into the resident's left arm without difficulty. 2. Record review of Resident #2's face sheet showed he/she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. -Malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). Record review of the resident's Quarterly MDS dated [DATE] showed he/she: -Was alert but had cognitive difficulty. -Was able to make his/her needs known. -Had no weight gain or loss. Observation on 3/3/20 at 2:28 P.M. of the medication room with Certified Medication Technician (CMT) A showed the medication refrigerator was pad locked and the temperature log sheet on the front had no temperature recorded. During an interview on 3/3/20 at 2:28 P.M., CMT A said: -The CMT's monitor for out dated medications and cleanliness of the medication room and the over counter medications. -The licensed nursing staff monitor and check the locked medication refrigerator. -The licensed nursing staff were the only staff that have keys for the medication refrigerator. Observation on 3/4/20 at 12:30 P.M., of the unlocked medication refrigerator with LPN B showed: -The refrigerator door was open. -The items were wet and water was dripping. -The thermometer read at 52 F and was rising. -LPN B was not aware the medication refrigerator was not working properly. -The temperature log located on front of the refrigerator had no temperature documented for March 2020. -LPN B said monitoring of the medication refrigerator had been the responsibility of the night shift nursing staff. During an interview on 3/4/20 at 12:38 P.M. LPN B said he/she had contacted his/her supervisor and the maintenance director to obtain a new refrigerator. Observation on 3/4/20 at 12:38 P.M., of medication stored in the medication refrigerator showed: -Resident #1, had one opened bottle of [MEDICATION NAME] (used for diabetes) 4 mcg/ml with an opened date of [DATE] (to be given every 12 hours). -Resident #2 had two-medication

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	265425	A. BUILDING _____ B. WING _____	03/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDGEWOOD MANOR HEALTH CARE CENTER	11900 JESSICA LANE RAYTOWN, MO 64138

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) cards of [MEDICATION NAME] 2.5 mg (one with nine pills and the other card with 30 pills). -Two boxes with one syringe in each box of [MEDICATION NAME] 37.5 mg inject one syringe every two weeks. -One vial of [MEDICATION NAME] (for mood disorder, anxiety). -Two vials of [MEDICATION NAME]100 U/ml vial. -One vial of [MED] Mix [MED] 75-25 ml. -One vial of [MEDICATION NAME] 100 Unit (U)/ml -Two vials of [MEDICATION NAME] [LOC]/ml. -Ten vials of [MEDICATION NAME] N [MED] 100 U/ml. -Three vials of [MEDICATION NAME] [MED] U100. -Two vials of [MEDICATION NAME] purified protein derivative, 5 [MEDICATION NAME] units (TU) per test dose of 0.1 ml. -Nine vials of Pneumococcal Vaccine ([MEDICATION NAME] 23). -45 syringes of [MEDICATION NAME] Quad (flu vaccine- 2019-20) 0.5 ml). -Five syringes of [MEDICAL CONDITION] vaccine. During an interview on 3/4/20 at 12:40 P.M. LPN B said: -He/she did not check the refrigerator temperature on the morning of 3/4/20. -He/she had accessed the locked refrigerator to obtain Resident #1's medication. -He/she had given Resident #1 his/her [MEDICATION NAME] AC injection on the morning of 3/4/20. -The medication was still cool to touch when he/she took it out of the medication refrigerator. -He/she did not feel any dripping water that morning. -The night shift nursing staff were responsible for checking and recording the refrigerator temperatures. During an interview 3/4/20 at 12:48 P.M., the Assistant Director of Nursing (ADON) said: -He/she had a different form for recording refrigerator temperatures. -Neither of the forms had temperatures documented. -Temperatures were to be documented on the temperature log by night shift nursing staff. During an interview on 3/4/20 at 2:41 P.M., the Administrator, Regional Nurse and ADON said the facility's pharmacy had been contacted and he/she was told two licensed nurses were to destroy the following medications due to the refrigerator temperatures being out of the recommended range: -Influenza vaccine ([MEDICATION NAME] Quad). --40 syringes were destroyed. -The facility had kept 5 to review with pharmacy when they arrive on site. -[MEDICAL CONDITION] vaccine. --Five syringes were destroyed. -Resident #1's one open vial of [MEDICATION NAME]. -[MEDICATION NAME]. --The facility had destroyed one vial. -Pneumococcal Vaccine. --The facility had destroyed nine vials. -[MEDICATION NAME] PPD. --The facility had destroyed two vials. -The [MED] had not been affected and was not destroyed. -The temperature logs were kept in the nurses Treatment Administration Record (TAR). Record review on 3/4/20 at 2:45 P.M., of the facility's medication refrigerator log sheet for March 2020 that was in the nurses TAR showed: -No temperatures were documented on [DATE] and [DATE]. -A temperature of 40F was documented on 3/3/20. During an interview on 3/5/20 at 2:11 P.M., the ADON and Regional Nurse said: -Monitoring of medication rooms and medication refrigerators were the responsibility of all nursing staff. -He/she expected night shift nursing to document the medication refrigerator temperatures nightly. -He/she expected all nursing staff who accessed the medication refrigerator, they should monitor the refrigerator temperatures to ensure they are within recommended range.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented to ensure no cross contamination was performed when two sampled residents' catheter bags (a flexible tube inserted through a narrow opening into the bladder, drains into a collection bag for removing fluid from the body) were on the floor (Resident #6 and #20); to ensure proper hand hygiene during catheter care for one sample resident (Resident #1) and during the transfer of one resident (Resident #20); to ensure proper storage of breathing tubing and masks when not in use for two sampled resident residents (Resident #32 and #33); and to include the following in its waterborne illness plan: a risk assessment of where opportunistic waterborne pathogens (e.g. Legionella sp. (a form of pneumonia, caused by the bacterium Legionella pneumophila found in both potable and nonpotable water systems, Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, and fungi) could grow and spread in potential areas of water stagnation; an accurate description of where the water enters into the facility; text flow diagrams of where the pipes from the various hot water heater were directed to; how the facility would react to changes in water quality such as water main breaks and construction; and the members of facility's Water Management program team in the facility's waterborne illness prevention plan. This practice potentially affected all residents and facility staff. The facility census was 48 residents. 1. Record review of Resident #6's Face Sheet showed he/she was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool to be completed by facility staff for care planning) dated 3/3/20, showed he/she: -Was alert, but had cognitive difficulty and memory problems. -Was totally dependent on staff for transfers, mobility, bathing, dressing, toileting and grooming. -Was incontinent and used a catheter for urination. Observation on 3/5/20 at 9:07 A.M., showed the resident was resting in his/her bed with his/her eyes closed. The resident's bed was in a low position and his/her catheter bag was touching the floor. The resident was resting comfortably with no signs or symptoms of pain or discomfort. During an interview on 3/5/20 at 9:21 A.M., Licensed Practical Nurse (LPN) D said: -The resident's catheter bag should always be kept below the resident's waist and should never be placed in his/her lap or touching the floor. -He/she went into the resident's room to pick the resident's catheter bag up off of the floor. During an interview on 3/5/20 at 2:09 P.M., the Assistant Director of Nursing (ADON) said the resident's catheter bag should always be kept below the resident's waist and off of the floor. 2. Record review of Resident #1's Admission Face sheet showed he/she had been admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. -[MEDICAL CONDITION] (gradual loss of kidney function). Record review of the resident's Admission MDS dated [DATE] showed he/she: -Was alert, and had no cognitive difficulty and memory problems. -Was totally dependent on staff for transfers, mobility, bathing, dressing, toileting and grooming. -Was incontinent at times and used a catheter for urination. -Had a Stage 4 pressure wound upon admission. Record review of the resident's physician's orders [REDACTED]. hold catheter in place) was to be changed monthly. -Change Foley catheter collection bag weekly on Wednesday. Observation on 3/5/20 at 10:00 A.M., of the resident's catheter care by Certified Nursing Assistant (CNA) A showed: -CNA A washed his/her hands upon entry of the resident's room and then applied gloves to his/her hands. -Used one wipe at a time for the resident's catheter care. -After CNA A finished catheter care, he/she pulled up the resident's bed sheets while wearing the same soiled gloves. -He/she then removed soiled gloves and emptied the resident's trash, removing it from the resident's room. -CNA A then returned to the resident's room to wash his/her hands with soap and water. During an interview on 3/5/20 at 10:15 A.M., CNA A said: -He/she should have washed his/her hands before he/she left the resident's room. -He/she should not have touched the resident's bed linens with soiled gloves. -He/she should have removed his/her gloves and washed his/her hands before handling the resident's bed sheets. During an interview on 3/5/20 at 1:04 P.M., the ADON and Regional nurse said: -He/she would expect care staff and nursing staff to perform hand hygiene before and after cares. -He/she would expect staff to remove gloves, wash hands, and put on clean gloves between a dirty and a clean process and then remove gloves and wash their hands after the care. -Staff should wash their hands upon entering the resident's room and apply gloves. -Staff should wash their hands before exiting the resident's room. -Staff should not touch linens or any items with soiled gloves or soiled hands. 3. Record review of Resident #33's [MEDICAL CONDITION] ([MEDICAL CONDITION], chronic lung damage which makes it difficult for your lungs to absorb enough oxygen) care plan dated 8/7/19 showed: -The resident had a potential complication of respiratory distress related to [MEDICAL CONDITION]. -He/she required oxygen as ordered. -Nursing staff were to provide medications as ordered. -Nursing staff were to monitor lung sounds and oxygen saturation via pulse oximetry (a test used to measure the oxygen level (oxygen saturation) of the blood) as ordered by the resident physician. -Did not indicate the resident had nebulizer breathing treatment as needed for [MEDICAL CONDITION]. Record review of the resident's Admission Face Sheet showed he/she was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of the resident's Quarterly MDS dated [DATE] showed he/she: -Had [DIAGNOSES REDACTED]. -He/she was able to make his/her needs known. -Did not indicate the resident had oxygen while resident. Record review of the resident's POS dated 3/1/20 to 3/31/20 showed an order for [REDACTED]. Observation on 3/2/20 at 3:23 P.M., showed the resident's nebulizer machine with tubing attached located on the bathroom sink counter and the tubing and mask was uncovered. Observation 3/3/20 at 10:40 A.M. of the resident's room showed: -The resident's nebulizer machine with tubing attached was located on the bathroom sink counter and the tubing and mask were uncovered. -He/she had one unopened vial of [MEDICATION NAME] medication next to the nebulizer machine. During an interview on 3/3/20 at 10:40 A.M. the resident said: -Normally the nursing staff setup the breathing treatment, but since he/she had been having shortness of breath the nursing staff had left one vial. -Just in case he/she had shortness of breath during the night, then the resident could provide on treatment right away. Observation on 3/4/20 at 12:45 P.M. of the resident's room showed his/her nebulizer machine, tubing and mask not covered laying on the bathroom sink. During an interview on 3/5/20 at 9:38 A.M., CNA A said: -The resident's O2 tubing and nebulizer tubing should be stored in plastics bags when not in use. -The night shift staff were responsible for changing the tubing weekly. During an interview on 3/5/20 at 1:43 P.M., the Regional Nurse and ADON said: -He/she would expect

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 7) nursing staff to ensure the resident's nebulizer tubing and face mask were stored in a plastic bag when not in use. 4. Record review of Resident #20's Face Sheet showed he/she: -Was admitted to the facility on [DATE]. -Had [DIAGNOSES REDACTED]. --Other lack of coordination. --[MEDICAL CONDITION] (paralysis) and [MEDICAL CONDITION] (slight paralysis/weakness) affecting the right side of the body following brain hemorrhage. --Generalized muscle weakness. --Retention of urine. Record review of the resident's Care Plan updated on 10/24/19 showed: -The resident had an indwelling supra-pubic catheter. -The resident required staff assistance with all Activities of Daily Living (ADL) tasks due to mobility issues related to [MEDICAL CONDITION] of right side, including: --Proper placement of his/her catheter bag below the level of his/her bladder. --Transfers to and from his/her wheelchair and bed. Record review of the resident's quarterly MDS dated [DATE] showed he/she: -Had an indwelling catheter. -Had functional limitations in range of motion on his/her upper and lower extremities on one side. -Required total assistance (full staff performance) with toilet use, including managing his/her catheter. -Required extensive assistance from at least two staff when transferring between bed and wheelchair. -The resident was only able to stabilize with staff assistance during transfers between bed and wheelchair. Record review of the resident's March 2020 POS showed the resident had a supra-pubic catheter (a sterile tube surgically inserted into the bladder through the lower abdomen to drain urine) due to a [DIAGNOSES REDACTED]. Observation on 3/2/20 at 9:29 A.M. showed the resident sitting in his/her wheelchair in the common area of the facility. The resident's catheter bag was secured under his/her wheelchair and was in a privacy bag. The privacy bag was touching the floor. Observation on 3/2/20 at 1:15 P.M. of the resident's transfer from his/her wheelchair to bed showed: -CNA E and CNA F were already in the resident's room with a mechanical lift (a mechanism that lifts and transfers a person from one place to another using a sling secured to a hydraulic lift) to assist the resident with transferring. -CNA E took gloves from his/her pocket and put them on, then touched the mechanical lift to move it out of the way. -CNA F put on gloves from a box on the counter, then touched a bedside table to roll it out of the way. -While wearing the same gloves, CNA E picked up the remote control to the resident's bed and moved the bed lower to assist with the transfer. -With contaminated gloved hands, CNA E unhooked the resident's catheter bag from under his/her wheelchair and hooked it low onto the bedframe close to where the resident was sitting with room for movement from the wheelchair to the bed. -With contaminated gloved hands, CNA F pushed the resident's wheelchair to a better transfer position by the bed. -Both CNAs then noticed that there was no mechanical lift sling under the resident so they would need to transfer him/her manually into the bed. -With contaminated gloved hands, CNA E got a clean washable bed pad from a side table and placed it in the middle of the resident's bed. -With contaminated gloved hands, both CNAs assisted the resident to rise from his/her wheelchair, balance, and pivot around to sit on the side of the bed while each supported the resident under each arm. -With contaminated gloved hands, CNA E assisted the resident with swinging his/her legs up onto the bed and the laying down. -With contaminated gloved hands, CNA E took off both of the resident's shoes. -With contaminated gloved hands, CNA E used the remote control to the resident's bed to lift the bed back up to a medium height. -With contaminated gloved hands, CNA F moved the resident's wheelchair to another part of the room. -With contaminated gloved hands, CNA E rolled the resident onto his/her left side and checked the resident's brief, which was clean and dry. -CNA F moved to the left side of the bed and CNA E to the right side of the bed. With contaminated gloved hands, both CNAs assisted the resident with removing his/her pants for comfort in bed. -CNA E carefully moved the resident's catheter bag and tubing through the leg of his/her pants as they were removed, then hung the catheter bag low on the bedframe. The catheter bag was not placed in a privacy bag. -CNA E asked the resident if he/she wanted to put on a hospital gown and he/she nodded his/her head up and down to indicate yes. -CNA E removed his/her gloves and held them in one hand. With the other hand, he/she touched the resident's right ear to look at something, then turned and opened the resident's door with the hand that was empty. He/she did not sanitize or wash his/her hands. -With contaminated gloved hands, CNA F pulled the sheet and blankets up over the resident's legs and abdomen. -CNA E returned to the room carrying a folded hospital gown. -CNA E took gloves from his/her pocket and put them on without being observed to wash or sanitize hands. -Both CNAs stood on each side of the resident's bed and removed his/her shirt and put the hospital gown on him/her. -CNA F removed his/her gloves, disposed of the gloves in the trash bin, and washed his/her hands with soap and water. He/she dispensed paper towels with his/her elbow, dried his/her hands, turned the water faucet off with the paper towel, and threw the paper towel into the trash bin. -Wearing the same gloves, CNA E picked up the resident's clothing and placed into a clear bag, then picked up the remote control to the resident's bed and elevated the head of the resident's bed to about 30 degrees. -CNA E removed his/her gloves, disposed of the gloves in the trash bin, and washed his/her hands with soap and water. He/she dispensed paper towels with his/her elbow, dried his/her hands, turned the water faucet off with the paper towel, and threw the paper towel into the trash bin. -CNA E took one glove from his/her pocket and put it on one hand. With his/her gloved hand, he/she removed trash bag from trash bin, picked up the bag of clothing, then opened the door with the ungloved hand and left the resident's room after making sure he/she was comfortable. During an interview on 3/2/20 at 1:27 P.M., CNA F said the only things he/she would do differently during the transfer process were: -It was best to transfer the resident using the mechanical lift, but staff had not placed the sling under the resident earlier that day, so they could not. -The resident's catheter bag should be placed in a privacy bag. During an interview on 3/2/20 at 1:29 P.M., CNA E said the only thing he/she would do differently during the transfer process was having the transfer the resident manually instead of using the mechanical lift. Observation on 3/2/20 at 2:09 P.M. showed the resident lying in bed watching television. His/her catheter bag was secured low on the bedframe. The catheter bag was not in a privacy bag and it was touching the floor. Observation on 3/2/20 at 2:56 P.M. showed the resident lying in bed watching television. His/her catheter bag was secured low on the bedframe. The catheter bag was not in a privacy bag and it was touching the floor. Observation at 3/5/20 at 10:50 A.M. showed the resident lying in bed watching television. He/she said he/she was comfortable with no issues. His/her catheter bag was secured low on the bedframe. The catheter bag was not in a privacy bag and it was touching the floor. 5. Record review of Resident #32's Face Sheet showed he/she: -Was admitted to the facility on [DATE]. -Had [DIAGNOSES REDACTED]. --[MEDICAL CONDITION] (a breathing condition characterized by low oxygen levels, high carbon [MEDICATION NAME] levels, and deterioration of the airways to the lungs). --Asthma (a breathing disorder that causes the airway to swell and produce thick mucus). --Heart Failure (severe failure of the heart to function properly). --Intellectual disabilities. Record review of the resident's Care Plan dated 8/27/19 showed: -The resident required oxygen therapy related to a history of [MEDICAL CONDITION] with interventions that included: -Encourage and remind the resident to keep the oxygen in place, including when he/she was in bed, as he/she had a tendency to remove the oxygen while sleeping. -Provide medications as ordered and encourage compliance with using nebulizer treatments and inhalers. Record review of the resident's March 2020 POS showed: -Oxygen - administer three liters per minute (l/m) via nasal cannula (an oxygen delivery tube with two small prongs that fit into the nostrils) to keep oxygen saturation (a measurement of how much oxygen the blood carries in comparison to its full capacity) above 90%. -[MEDICATION NAME] Inhalation Solution (a medication that is inhaled using a nebulizer (a device used to administer medication to people in the form of a mist inhaled into the lungs) to treat and prevent symptoms such as wheezing and shortness of breath) - inhale one vial per nebulizer every two hours as needed for [MEDICAL CONDITION]. Observation on 3/3/20 at 8:43 A.M. showed: -The resident was sleeping in bed with the oxygen concentrator running at 3 l/m. The resident was wearing the nasal cannula. -A nebulizer sat on a small dresser next to the head of the resident's bed, not running, with the tubing and mask lying directly on the top of the cluttered dresser and partially covered with a shirt. No storage bag for the nebulizer tubing and mask was observed. Observation on 3/3/20 at 11:19 A.M. showed: -The resident was not in his/her room. The oxygen concentrator was off and the tubing was partially lying on the concentrator machine and partially on the floor. No storage bag for the oxygen tubing and nasal cannula was observed. -A nebulizer sat on a small dresser next to the head of the resident's bed, not running, with the tubing and mask lying directly on the top of the cluttered dresser and partially covered with a shirt. No storage bag for the nebulizer tubing and mask was observed. Observation on 3/3/20 at 1:05 P.M. showed: -The resident was not in his/her room. The oxygen concentrator was off and the tubing with the nasal cannula attached was wound around the humidifier bottle on the concentrator machine. Neither the tubing nor the nasal cannula were stored in a bag and no storage bag was observed. -A nebulizer sat on a small dresser next to the head of the resident's bed, not running, with the tubing and mask lying directly on the top of the cluttered dresser and partially covered with a shirt. No storage bag for the nebulizer tubing and mask was observed. Observation on 3/4/20 at 10:00 A.M. showed: -The resident was asleep in bed. The oxygen concentrator was running at 3 l/m and the oxygen tubing and nasal cannula were laying on the floor next to the bed. -A nebulizer sat on a small dresser next to the head of the resident's bed, not running, with the tubing and mask lying directly on the top of the cluttered dresser and partially covered with a shirt. No storage bag for the nebulizer tubing and mask was observed.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 8) Observation on 3/4/20 at 12:22 P.M. showed: -The resident was not in his/her room. The oxygen concentrator was off and the tubing was partially lying on the concentrator machine and partially on the floor. -On the top of a small dresser near the oxygen concentrator at the foot of the resident's bed was a gallon-size plastic zip-close bag among many other various items. There was writing on the bag that said, O2 (oxygen) cannula 2/2/20. The bag was empty. -A nebulizer sat on a small dresser next to the head of the resident's bed, not running, with the tubing and mask lying directly on the top of the cluttered dresser and partially covered with a shirt. No storage bag for the nebulizer tubing and mask was observed. Observation on 3/4/20 at 1:30 P.M. showed: -The resident was not in his/her room. The oxygen concentrator was off and the tubing was partially lying on the concentrator machine and partially on the floor. -On the top of a small dresser near the oxygen concentrator at the foot of the resident's bed was a gallon-size plastic zip-close bag among many other various items. There was writing on the bag that said, O2 (oxygen) cannula 2/2/20. The bag was empty. -A nebulizer sat on a small dresser next to the head of the resident's bed, not running, with the tubing and mask lying directly on the top of the cluttered dresser and partially covered with a shirt. No storage bag for the nebulizer tubing and mask was observed. Observation on 3/5/20 at 8:35 A.M. showed: -The resident was sleeping in bed with the oxygen concentrator running at 3 l/m. The resident was wearing the nasal cannula. -On the top of a small dresser near the oxygen concentrator at the foot of the resident's bed was a gallon-size plastic zip-close bag among many other various items. There was writing on the bag that said, O2 (oxygen) cannula 2/2/20. The bag was empty. -A nebulizer sat on a small dresser next to the head of the resident's bed, not running, with the tubing and mask lying directly on the top of the cluttered dresser and partially covered with a shirt. No storage bag for the nebulizer tubing and mask was observed. 6. During an interview on 3/5/20 at 10:45 A.M., CNA C said: -Oxygen tubing, cannulas, and masks should be bagged when not in use and should not be on the floor. -Catheter bags and tubing should not touch the floor. -Staff should wash or sanitize hands before providing any kind of care to a resident where they will touch the resident, before putting on gloves, after removing gloves, any time hands or gloves are visibly soiled, and any time something is touched that could be unclean before continuing to provide care to a resident. During an interview on 3/5/20 at 10:33 A.M., Registered Nurse (RN) A said: -All tubing for any type of oxygen support, including nasal cannulas and masks, should be bagged when not in use and should never be on the floor. -There are not always plastic bags available, so nursing staff need to go to dietary to get new plastic zipper bags to use for bagging oxygen tubing, cannulas, and masks. -CNAs and nurses should always put the oxygen equipment in bags if they see it is not bagged. -Catheter bags should not touch the floor. -Staff are trained to sanitize or wash hands before any resident care, before and after glove changes, and when hands are visibly soiled. If a staff is in doubt about whether they should change gloves and/or sanitize hands. During an interview on 3/5/20 at 2:09 P.M., the ADON and the Regional Nurse said: -It was expected that staff wash hands: --Prior to and after resident care. --Before, between, and after glove changes. --If hands or gloves are visibly soiled. -Catheter bags should not touch the floor. -Oxygen tubing, nasal cannulas, mouthpieces, and masks should be stored in a dated bag when not in use and should not touch the floor. -If a CNA saw oxygen equipment on the floor, it was expected that they tell a nurse and the nurse should discard the equipment and replace it. -If a nurse saw oxygen equipment on the floor, it was expected that they should discard it and replace it 7. Record review of the Centers for Medicare and Medicaid Services (CMS) Survey and Certification letter dated 6/2/17, showed: -The facility should develop and implement a water management program that considers the American Society of Heating Refrigerating and Air Conditioning Engineers (ASHRAE) industry standard and the CDC toolkit. -The toolkit should contain the following: text and flow diagrams, identify areas where Legionella could grow and spread, that the team has conducted a water program review at least annually, as stated. -The annual review should: 1) be implemented; 2) record findings and updates; 3) record participants; and 4) be submitted to the Executive Director. Observation throughout the facility during the survey dated 3/2/20 through 3/5/20, showed eight vacant rooms in the facility, with the increased risk of harmful bacteria growth in the unused sinks located in those rooms. Record review of the facility's undated Legionella/Waterborne Illness plan, showed the absence of the following: - A risk assessment of where (vacant resident rooms) opportunistic water pathogens could grow and spread. - A flow diagram which described where the water came into the building and the routes from the various water heaters throughout the facility, to the various halls. - A plan on what corrective actions the facility would implement in response to a water main break and construction. - A plan for specific actions that would be taken in response to a Legionella sp. Positive water sample. -The members of the water management team. During an interview on 3/5/20 at 9:52 A.M., the Interim Administrator said: -Diagrams were needed to show where water came into the building. -That the reaction to a water main break or construction would need to be in the plan as well as specific actions that would be implemented, if there was a Legionella sp. -Members of the water management team should be listed in the plan.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observation, interview and record review, the facility failed to ensure a dead mouse and mouse droppings (the excrement of certain animals, such as rodents, sheep, birds, and insects) were removed from the kitchen furnace room for three days of the survey. This practice potentially affected one non-resident use area. The facility census was 48 residents. 1. Observations on 3/2/20 at 8:29 A.M., 3/3/20 at 10:23 A.M. and 3/4/20 at 8:27 A.M., showed the presence of a dead mouse and mouse droppings in the kitchen furnace room. During an interview on 3/3/20 at 10:22 A.M., the Maintenance Director said he/she did not know about the dead mouse in the kitchen furnace room. During an interview on 3/4/20 at 8:28 A.M., the Dietary Manager (DM) said he/she had not seen the mouse and the mouse droppings in the dietary furnace room. Record review of the 1999 and 2009 Food and Drug Administration (FDA) Food Code and [ST] Food Codes, showed: 6-501.111 Controlling Pests. The PREMISES shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the PREMISES by: (A) Routinely inspecting incoming shipments of FOOD and supplies; (B) Routinely inspecting the PREMISES for evidence of pests; (C) Using methods, if pests are found, such as trapping devices or other means of pest control as specified under 7-202.12, 7-206.12, and 7-206.13; Pf and (D) Eliminating harborage conditions. 6-501.112 Removing Dead or Trapped Birds, Insects, Rodents, and Other Pests. Dead or trapped birds, insects, rodents, and other pests shall be removed from control devices and the PREMISES at a frequency that prevents their accumulation, decomposition, or the attraction of pests.