STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265460	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASSVILLE HEALTH CENTER FOR REHAB AND HEALTHCARE	1300 COUNTY FARM ROAD CASSVILLE, MO 65625

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to notify one resident's (Resident #1) physician in a timely manner when the resident had an increase in behaviors, some of which were potentially hazardous in nature and required medication administration. The facility census was 43. Record review of the facility's policy, titled Change in a Resident's Condition or Status, dated November 2015, showed the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On Call Physician when there has been: -An accident or incident involving the resident; -A discovery of injuries of unknown source; -A reaction to medication; -A significant change in the resident's physical/emotional/mental condition; -A need to alter the resident's medical treatment significantly; -Refusal of treatment or medications (two or more consecutive times); -A need to transfer the resident to a hospital/treatment center; -A discharge without proper medical authority; -Instructions to notify the physician of changes in the resident's condition. 1. Record review of Resident #1's face sheet showed the following: -admitted [DATE]; -[DIAGNOSES REDACTED]. orders showed the following: -An order dated 07/08/2020, for [MEDICATION NAME] (a medication used to treat anxiety) 2 milligrams (mg) per milliliter (ml) sublingually (under the tongue) every two hours as needed for agitation or restlessness; -An order dated 07/08/2020,for [MEDICATION NAME] 0.5 mg tablet, one tablet by mouth every two hours as needed for agitation. Record review of the resident's baseline care plan (a care plan done within 48 hours of admission which contains the minimum information needed to properly care for a resident), dated 07/09/2020, showed the following: -Resident was alert/confused; -Resident was an elopement risk; -Resident's behavior concerns included: hallucinations, agitation, roaming, and confusion; -Interventions included monitor exit seeking, place interventions as needed, and monitor aggressive behavior if needed. (The care plan did not direct staff to notify the physician of any changes in behavior or to notify physician of aggressive behaviors.) Record review of the resident's nurse's note dated 07/10/2020, at 4:15 A.M., showed the resident stepped out of the fire exit door, setting alarm off. Staff responded. Staff were able to redirect the resident back to bed. Staff notified the administrator notified of escape attempt. Record review of the resident's medical record showed staff did not document notifying the resident's physician of the attempted elopement. Record review of the resident's nurse's note dated 07/10/2020, at 5:00 A.M., showed the resident was working on the air unit. The resident had the cover off with the unit plugged in. Staff moved the resident closer to the nurses' station for closer observation. Record review of the resident's medical record showed staff did not document notifying the resident's physician of the potentially unsafe behavior. Record review of the resident's nurse's note dated 07/12/2020, at 9:00 A.M., showed the resident was crawling under the bed trying to fix this thing. Resident was very confused. When staff attempted to redirect, resident got combative. Staff administered as needed (PRN) [MEDICATION NAME] ([MEDICATION NAME]). Record review of the resident's July 2020 Medication Administration Record [REDACTED].M., staff administered [MEDICATION NAME] two mg by mouth at to the resident for agitation and anxiety. Record review of the resident's medical record showed staff did not document notifying the resident's physician of the behavior, combativeness, or required medication administration. Record review of the resident's nurse's note dated 07/12/2020, at 11:00 A.M., showed the resident was throwing contents of trash can all over the room, wearing the trash can as a hat, and sitting in the trash can. Record review of the resident's July 2020 MAR indicated [REDACTED].M., showed staff administered [MEDICATION NAME] two mg by mouth to the resident for agitation. Record review of the resident's medical record showed staff did not document notifying the resident's physician of the behavior. Record review of the resident's nurse's note dated 07/12/2020, at 3:00 P.M., showed the resident was extremely anxious. Resident was flipping over the bedside table, throwing things across the room, looking for his/her spouse, talking to people who were not there, and reaching for things that were not there. Staff administered PRN [MEDICATION NAME]. Record review of the resident's July 2020 MAR indicated [REDACTED].M., staff administered [MEDICATION NAME] two mg by mouth to the resident for anxiety. Record review of the resident's medical record showed staff did not document notifying the resident's physician of the behavior or required medication administration. Record review of the resident's nurse's note dated 07/13/2020, at 8:45 P.M., showed the resident crawled out of bed and to the electrical outlet by the air unit. The resident pulled the trim from the wall and pried the wall plate off breaking it. The resident had an abrasion (scrape) above his/her left eyebrow. Resident assisted up and to the nurses' station for closer observation. Record review of the facility's Maintenance Repair Form, dated 07/14/2020, showed the following: -Location: Room identified as Resident #1's room. -Item to be repaired: An electric plug, air conditioner cover, trim, and wall fire blanket box. -Identify problem if possible: Resident is breaking things. -The description of the problem was identified as: Resident broke off air conditioner front so he/she could repair it. Electrical plug cover broken off and plug hanging partially out of the wall. Resident says he/she was fixing the electric. Pushed exposed wires back in and remounted the plug back into the wall. Purchased a new cover and replaced. The trim was broken and torn from the wall. Resident said he needed nails for tools to work on the air conditioner because it wasn't on. Patched sheet rock and cut new trim and nailed in place. Repaired gouges (make a groove, hole or indentation) in the wall used nails to dig for electrical wires. Epoxied weld latches back on cover and rehang. Resident said he was cold and needed the blanket. Record review of the resident's medical record showed staff did not document notifying the resident's physician of the potentially unsafe behavior. Record review of the resident's nurse's note dated 07/14/2020, at 8:00 A.M., showed fall follow-up with neuro checks (an assessment to evaluate the resident's level of mental function), bruising and lacerations (cut) to left eye, and cheek. Resident denied pain. Resident continued to wander halls. Staff took resident for a shower and resident kept grabbing the shower head and reaching for everything. When the resident was given a washcloth, the resident started scrubbing the walls, and got agitated when staff attempted to assist. Staff administered PRN [MEDICATION NAME]. Record review of the resident's July 2020 MAR indicated [REDACTED].M., staff administered [MEDICATION NAME] two mg by mouth to the resident for anxiety and restlessness. Record review of the resident's medical record showed staff did not document notifying the resident's physician regarding the fall or the incident in the shower. During an interview on 7/14/2020, at 5:50 P.M., Licensed Practical Nurse (LPN) A said the resident had to be brought to the nurses' station a lot for observation. He/she had to be brought to the nurses' station on the night of 7/13/2020 because he/she had pulled the trim off the wall in his/her room. The administrator was called and made aware. During an interview on 7/15/2020, at 8:25 A.M., the Social Services Director said she was aware of the resident tearing up his room. The physician should be notified any time there is a change in a resident's behaviors. It is facility protocol. The notification should be documented in the nurses' notes. During an interview on 7/15/2020, at 10:05 A.M., Registered Nurse (RN) B said it was reported to him/her that the resident had been wandering and had torn up his/her room. He/she is unsure if those incidents had been reported to the physician. Increased negative behaviors, elopements, and aggressiveness are supposed to be reported so medication adjustments can be made if needed. During an interview on 7/15/2020, at 10:15 A.M., LPN C said if a

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

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident has a change in mental status or change in behaviors he/she would call the physician. He/she was unsure if the physician had been notified about the resident. During an interview on 7/15/2020, at 11:40 A.M., the Director of Nursing and Administrator said the physician is normally notified of a change of condition unless it is a normal behavior. Staff would notify the physician of new behaviors. The resident's behaviors were not really new, but progressed rather than changed from baseline. MO 648