STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26A490	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FIESER NURSING CENTER	**404 MAIN STREET FENTON, MO 63026**

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 0577 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.** Based on observation, interview and record review, the facility failed to maintain survey reports with respect to surveys, certifications and complaint investigations made during the preceding year, and any plan of correction in effect with respect to the facility. The census was 37. Observation on all days of the survey, from 3/1/20 through 3/4/20, showed a sign on the wall at the front entrance which read: surveys, certifications and complaint investigations made during the preceding three years from the Department of Health and Senior Services, are located in the living room area on the far wall, in a wall pocket, available 24 hours. Review of the survey binder, located in the living room area on the far wall, inside a wall pocket, showed no surveys and certifications dated 4/10/19 and 6/7/19 and any plan of correction in effect. During an interview on 3/4/20 at 11:30 P.M., the administrator said she was unaware the binder at the front entrance did not contain information for 2019. The survey binder should be complete and contain all entries for the previous three years.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete comprehensive resident assessments using the Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, within 14 calendar days after admission to the facility, and not less than every twelve months, for nine out of 16 sampled residents (Residents #31, #8, #6, #25, #188, #12, #32, #13 and #12). The census was 37. 1. Review of Resident #31's MDS record, showed: -An annual MDS, dated [DATE]; -No annual MDS for September 2019 completed. 2. Review of Resident #8's MDS record, showed: -An admission MDS, dated [DATE]. -No annual MDS for September 2019 completed. 3. Review of Resident #6's MDS record, showed: -An annual MDS, dated [DATE]; -No annual MDS for February 2020 completed. 4. Review of Resident #25's MDS record, showed: -An admission MDS, dated [DATE]; -No annual MDS for June 2019 completed. 5. Review of Resident #188's MDS record, showed: -An annual MDS, dated [DATE]; -No annual MDS for November 2019 completed. 6. Review of Resident #12's MDS record, showed: -An Annual MDS, dated [DATE]; -No annual MDS for February 2019 or 2020 completed. 7. Review of Resident #32's MDS record, showed: -An annual MDS, dated [DATE]; -No annual MDS for August 2019 completed. 8. Review of Resident #13's MDS record, showed: -An annual MDS, dated [DATE]; -No annual MDS for October 2019 completed. 9. Review of Resident #12's MDS record, showed: -An annual MDS, dated [DATE]; -No annual MDS for February 2019 and February 2020 completed. 10. During an interview on 3/4/20 at 9:21 A.M., the administrator said the previous Director of Nursing (DON) was responsible for ensuring the MDS were completed prior to him/her leaving the facility February 2020. Since he/she left, they have not had anyone sign off on them. The facility is also without an MDS coordinator. The administrator discovered last week that there were MDS that were late or not transmitted. She would expect the MDS to be completed timely. She would expect the MDS report to be printed monthly to show which residents are due for their quarterly MDS. The administrator confirmed the facility does not have a MDS policy.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** Based on interview and record review, the facility failed to ensure a resident's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, was completed within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition for one of one resident investigated for hospice/end of life care (Resident #88). The census was 37. Review of Resident #88's medical record, showed the resident admitted to hospice on 2/5/20. Review of the resident's MDS record, showed no significant change MDS completed after the resident admitted to hospice. During an interview on 3/4/20 at 9:00 A.M., the administrator said she would expect significant change MDS be completed as required.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess residents using the quarterly review Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, for five of 16 sampled residents (Residents #13, #9, #188, #19 and #12). The census was 37. 1. Review of Resident #13's MDS record, showed: -An annual MDS, dated [DATE]; -No quarterly MDS for July 2019; -A quarterly MDS, dated [DATE]; -No quarterly MDS for January 2020 completed. 2. Review of Resident #9's MDS record, showed: -An admission MDS, dated [DATE]; -Quarterly MDS, dated [DATE] and 10/18/19; -No quarterly MDS for January 2020 completed. 3. Review of Resident #188's MDS record, showed: -An annual MDS, dated [DATE]; -Quarterly MDS, dated [DATE], 5/13/19 and 8/8/19; -No quarterly MDS for February 2020 completed. 4. Review of Resident #19's MDS record, showed: -An annual MDS, dated [DATE]; -A quarterly MDS, dated [DATE]; -No quarterly MDS for September 2019 completed. 5. Review of Resident #12's MDS record, showed: -An annual MDS, dated [DATE]; -Quarterly MDS, dated [DATE] and 11/4/19; -No quarterly MDS for August 2019. 6. During an interview on 3/4/20 at 9:21 A.M., the administrator said the previous Director of Nursing (DON) was responsible for ensuring the MDS were completed prior to him/her leaving the facility February 2020. The facility is without a MDS coordinator. The administrator discovered last week that there were MDS that were late or not transmitted. She would expect the MDS to be completed timely. She would expect the MDS report to be printed monthly to show which residents are due for their quarterly MDS.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.**

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to complete and transmit required Minimum Data Sets (MDS), a federally mandated assessment instrument completed by facility staff, assessments for five residents (Residents #9, #188, #12, #4, and #23) of 16 sampled residents. The facility census was 37. 1. Review of Resident #9's MDS record, showed: -A discharge return anticipated MDS, dated [DATE], accepted; -An entry MDS dated [DATE], finalized and not transmitted; -A quarterly MDS, dated [DATE], accepted; -A quarterly MDS, dated [DATE], in progress and not transmitted; -A discharge return anticipated MDS, dated [DATE], finalized and not transmitted; -An entry MDS, dated [DATE], finalized and not transmitted. 2. Review of Resident #188's MDS record, showed: -A significant change MDS, dated [DATE], validated and not transmitted; -A quarterly MDS, dated [DATE], accepted; -An annual MDS, dated [DATE], in process and not transmitted; -A quarterly MDS, dated [DATE], in process and not transmitted. 3. Review of Resident #12's MDS record, showed: -An annual MDS, dated [DATE], validated and not transmitted; -A quarterly MDS, dated [DATE], accepted; -A quarterly MDS, dated [DATE], accepted; -A quarterly MDS, dated [DATE], accepted; -An annual MDS, dated [DATE], in process and not transmitted. 4. Review of Resident #4's MDS record, showed: -A quarterly MDS, dated [DATE], accepted; -An annual MDS, dated [DATE], validated and not transmitted. 5. Review of Resident #23's MDS record, showed: -A quarterly MDS, dated [DATE], as accepted; -A significant change MDS, dated [DATE], validated and not transmitted. 6. During an interview on 3/4/20 at 9:21 A.M., the administrator said the previous Director of Nursing (DON) was responsible for ensuring the MDS were completed prior to him/her leaving the facility February 2020. Since he/she left, they have not had anyone sign off on them. The facility is also without an MDS coordinator. The administrator discovered last week that there were MDS that were late or not transmitted. She confirmed that the MDS had not been transmitted since the former DON left. She would expect the MDS to be completed timely.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, regarding hospice services, diagnoses and the use of oxygen therapy, for five of 16 sampled residents (Residents #6, #23, #25, #31 and #20). The census was 37. 1. Review of Resident #6's electronic physician's orders [REDACTED]. Review of the resident's quarterly MDS, dated [DATE], showed: -Diagnoses included heart failure, diabetes, anxiety, and [MEDICAL CONDITION]; -Life expectancy less than six months; -Hospice, not marked. 2. Review of Resident #23's ePOS, dated 3/1/20 through 3/31/20, showed: -An order, dated 8/21/19, hospice to evaluate and treat. Review of the resident's annual MDS, dated [DATE], showed: -Diagnoses included [MEDICAL CONDITION] and anxiety; -Receives hospice care; -Prognosis less than six months: No. 3. Review of Resident #25's medical record, showed diagnoses included dementia without behavioral disturbance, restlessness and agitation, partial loss of teeth, acute upper respiratory infection, abrasion of left elbow, abnormal weight loss, non-pressure chronic ulcer of part of foot, major [MEDICAL CONDITION], pressure ulcer of left upper back, stage 2, restlessness and agitation, [MEDICAL CONDITION], vitamin deficiency, constipation, shortness of breath, pain, muscle weakness, and high blood pressure. Review of the resident's quarterly MDS, dated [DATE], showed: -Rarely understood; -Disorganized thinking; -No behaviors; -Total dependence in bed mobility, transfers, dressing, toileting, and hygiene; -No diagnoses selected. 4. Review of Resident #31's ePOS, dated 3/1/20 through 3/4/20, showed: -An order dated 8/14/19, to change oxygen tubing and humidifier bottle every week on Sunday; -An order dated 2/5/20, oxygen at 2 liters at all times for [DIAGNOSES REDACTED]. Review of the resident's medical record, showed diagnoses included heart failure. Review of the resident's quarterly MDS, dated [DATE]; -Rarely/never understood; -Diagnoses included anxiety and depression; -Use of oxygen not documented; -Diagnoses of heart failure and [MEDICAL CONDITION] not documented. 5. Review of Resident #20's annual MDS, dated [DATE], showed: -Cognitively intact; -Oxygen therapy not indicated as used. -Diagnoses included diabetes and elevated cholesterol. Review of the resident's ePOS, dated 3/1/20 through 3/31/20, showed; -An order dated 11/29/19, for oxygen at 2-3 Liters per nasal cannula, for shortness of breath, as needed; -An order dated 12/4/19, to change oxygen tubing and humidifier bottle every week on Sundays when in use. 6. During an interview on 3/4/20 at 9:21 A.M., the administrator said the previous Director of Nursing (DON) was responsible for ensuring the MDS were completed prior to him/her leaving the facility February 2020. Since he/she left, they have not had anyone sign off on them. The facility is also without an MDS coordinator. She would expect the MDS to be accurate and reflect the needs of the resident.
F 0642 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a qualified health professional conducts resident assessments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a registered nurse (RN) signed and certified that the Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, was completed for three of 16 sampled residents (Residents #9, #188 and #12). The facility census was 37. 1. Review of Resident # 9's medical record, showed an admission MDS, dated [DATE], no Care Area Assessment Summary (CAAS) completed and no registered nurse (RN) signature. 2. Review of Resident #188's medical record, showed a significant change MDS, dated [DATE], no RN signature. 3. Review of Resident #12's medical record, showed an Annual MDS date 2/25/19, no RN signature. 4. During an interview on 3/6/20 at 1:20 P.M., the administrator said the former Director of Nursing had been a RN and had left the facility. The facility had hired a consultant RN recently, but he/she had not started at the time of the interview. The MDS assessments had not been reviewed or signed by an RN.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a preadmission Screening for individuals with a mental disorder and individuals with intellectual disability by failing to ensure a resident had a DA-124 Level I screen (used to evaluate for the presence of psychiatric conditions to determine if a preadmission screening/resident review (PASARR) Level II screen is required) as required, for one of 16 sampled residents (Resident #29) The census was 37. Review of Resident #29's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/6/20, showed the following: -Date of admission on [DATE]; -No screening information regarding PASARR, Level II PASARR, or conditions related to serious mental illness/intellectual disabilities/related conditions; -[DIAGNOSES REDACTED]. Review of the resident's medical record, showed no documentation of a DA-124 Level I screen and no documentation of a PASARR Level II screen. During an interview on 3/3/20 at 11:23 A.M., the administrator confirmed that the facility admitted the resident without a DA-124 Level I screen.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission for three of 16 sampled residents (Residents #20, #237 and #22). The census was 37. 1. Review of Resident #20's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/1/19, showed: -admitted , 11/29/19; -Cognitively intact; -One staff assist for transfer, dressing and toileting; -Set up only for eating; -Wheelchair for mobility; -[DIAGNOSES REDACTED]. Review of the medical record, showed a baseline care plan not completed until 12/10/19. 2. Review of Resident #237's medical record, showed: -admitted [DATE]; -Admission fall risk assessment, showed the resident a fall risk; -No baseline care plan completed. 3. Review of Resident #22's medical record, showed: -admitted [DATE]; -An admission skin assessment, showed the resident admitted with a wound; -No baseline care plan completed. 4. During an interview on 3/4/20 at 9:00 A.M., the administrator said she would expect baseline care plans be completed as required.

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2)
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific care needs of the residents, for two of 16 sampled residents (Residents #20 and #19). The census was 37. 1. Review of Resident #20's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/1/19, showed: -Cognitively intact; -Oxygen therapy not indicated as used. -[DIAGNOSES REDACTED]. Review of the resident's electronic physician order [REDACTED]. Observation and interview on 3/1/20 at 1:48 P.M., showed an oxygen concentrator sat against the wall in the resident's room. The resident said he/she rarely used oxygen, it is used only when he/she needs it. A yellow note on the front of the concentrator, dated 10/10, and the tubing and nasal cannula hung from the front of the concentrator, uncovered. Review of the resident's care plan, dated 12/10/19, showed: -Problem: At risk for falling due to muscle weakness; -Problem: Limited ability to walk in room due to muscle weakness; -Problem: At risk for malnutrition due to no natural or missing teeth; -Problem: Impaired vision due to [DIAGNOSES REDACTED]. 2. Review of Resident #19's quarterly MDS, dated [DATE], showed: -Cognitively intact; -Behaviors included: verbal and physical towards others, rejection of care, wandering, four to six days a week; -Assist of two staff for bed mobility and transfers; -Assist of one staff for personal hygiene, dressing and toileting; -Set up only for eating and locomotion off unit; -Wheelchair for mobility; -Pain medication as needed (PRN), received/refused; -No routine pain medication; -Pain presence, yes; -Frequency, almost constantly; -[DIAGNOSES REDACTED]. Review of the resident's ePOS, showed an order dated 2/12/20, for [MEDICATION NAME] (a nerve pain medication and anti-[MEDICAL CONDITION]), 100 milligrams (mg), 1 capsule three times a day (Diagnosis: [REDACTED]. Review of the resident's Medication Administration Record, [REDACTED]. During an interview on 3/1/20 at 1:10 P.M., the resident said he/she was in a motor vehicle accident and now always has pain and he/she is used to it. Review of the resident's care plan, dated 6/8/15 and revised on 12/10/19, showed: -Problem: Requires assistance with activities of daily living related to side effects of stroke, [MEDICAL CONDITION] and joint weakness secondary to EDS ([DIAGNOSES REDACTED] syndrome, is a rare genetic disorder involving connective tissue that causes joint hypermobility and widespread pain); -Approach: Social services to meet with resident weekly to ensure needs are being met. Assist in a Hoyer lift (mechanical lift) for transfer into wheelchair and bed for bedpan usage with two staff. Picks out own clothing, assist with dressing; -No direction to staff in regard to pain, pain medication usage, nursing/physician notification of pain, and/or possible alternative pain alleviating interventions. 3. During an interview on 3/4/20 at 10:54 A.M., the administrator said resident care plans should reflect the individual resident's needs.
F 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive discharge summary for one of two resident investigated discharges (Resident #38). The census was 37. Review of the facilities Discharge/Transfer of Resident policy, dated 3/15, showed: -Purpose: To provide a safe departure from the facility and provide sufficient information for the aftercare of the resident; -Equipment: Resident medical record, Discharge order; -Discharge summary and post discharge plan of care forms (for discharge to home, lower level of care or other long term care facilities); -Discharge: -Complete a discharge summary and post discharge plan of care form; -Include list of medications; -Include instructions for post discharge care and explain to the resident and/or representative; have resident and/or representative or person responsible for care sign discharge summary and post discharge care form; give a copy of the form to the resident and/or representative or person responsible for care; place a signed original of the form in the medical record; -Check belongings and inventory sheet form, have resident and/or representative or responsible care giver sign for belongings and place original in chart. Review of Resident #38 electronic medical record, showed: -Physician order [REDACTED].M., the Administrator said he/she was not there when the resident discharged and no discharge summary or post discharge care documentation was documented.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were provided personal care and hygiene per resident wishes and standards of practice for five residents (Residents #20, #12, #188, #8 and #29). The sample was 16. The census was 37. Review of the facility's nail care policy, dated 3/2015, showed: -Purpose: To provide cleanliness, comfort and prevent the spread of infection. The nursing aides may perform nail care on the residents who are not at risk of infection. A licensed nurse or podiatrist will perform nail care on residents with diabetes and vascular disease. 1. Review of Resident #20's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/1/19, showed: -Cognitively intact; -One staff assist for transfers, dressing and toileting; -Set up only for eating; -Wheelchair for mobility; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 12/10/19, showed: -Problem: At risk for malnutrition due to no natural or missing teeth; -Approach: Monitor and record intake of food; -Problem: Impaired vision due to [DIAGNOSES REDACTED]. Observation of the resident, showed: -On 3/1/20 at 1:44 P.M., the resident sat in a chair in his/her room, with the front of his/her shirt soiled, and his/her chair cushion covered in multiple areas with a dried substance; -On 3/2/20 at 7:36 A.M., the resident sat in the main dining room. He/she wore the same soiled shirt from the previous day; -On 3/4/20 at 11:45 A.M., the resident sat in the dining room, with the front of his/her shirt soiled. During an interview on 3/4/20 at 11:21 A.M., the administrator said she expected staff to change resident's clothing when they see the clothing is soiled. 2. Review of Resident #12's medical record, showed: -Extensive staff assistance needed with transfers and toileting; -Total staff assistance needed with personal hygiene and bathing; -[DIAGNOSES REDACTED]. Review of the resident's care plan, revised on 11/28/18, showed: -Problem: The resident needs staff assistance with care related to his/her decline in strength; -Goal: Participate in care tasks; -Approach: Staff to assist with dressing, personal hygiene and bathing. Observations of the resident during the survey, showed on 3/1/20 at 2:00 P.M., 3/2/20 at 7:05 A.M., 11:22 A.M., 3:10 P.M. and 6:17 P.M., and on 3/4/20 at 9:03 A.M., the resident's nails noted to be long and contained a dark brown substance noted under all fingernail beds. 3. Review of Resident #188's medical record, showed: -Extensive staff assistance needed with hygiene and toileting; -Total staff assistance needed for showering; -[DIAGNOSES REDACTED]. Review of the care plan, revised on 2/11/19, showed: -Problem: The resident needs staff assistance with care related to physical weakness; -Goal: The resident will participate in care tasks; -Approach: Staff to assist with grooming, personal hygiene and bathing. The hospice aide will assist with bathing. Observations of the resident during the survey, showed on 3/1/20 at 1:20 P.M. and 3:45 P.M., on 3/2/20 at 6:08 A.M., 10:33 A.M., 12:18 P.M. and at 5:12 P.M., and on 3/4/20 at 9:02 A.M., the resident noted to have several fingers with long jagged nails. Dark brown substance noted under all of the fingernails. During an interview on 3/4/20 at 1:15 P.M., the Director of Nursing (DON) said it is the responsibility of all nursing staff to ensure that resident fingernails are clean and trimmed. Unkempt nails could risk infection or scratches on the resident's skin. 4. Review of Resident #8's quarterly MDS, dated [DATE], showed: -Cognitively impaired; -No behaviors; -Assist of one staff for bed mobility, transfers, personal hygiene, dressing and toileting; -Set up only for eating and locomotion off unit; -Wheelchair for mobility; -[DIAGNOSES REDACTED]. Observation and interview on 3/1/20 at 2:00 P.M., showed the resident sat in the main dining room and visited with a family member with long hairs on the resident's chin. The resident's family member stated the hair on the resident's chin should be removed on a regular basis.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) Observation on 3/2/20 at 7:24 A.M., showed the resident sat in the main dining room and ate breakfast, with long hairs on his/her chin. On 3/3/20 at 10:10 A.M., the resident sat in the main dining room, with long hairs on his/her chin. On 3/4/20 at 7:55 A.M., the resident sat in his/her wheelchair, with long hairs on his/her chin. During an interview on 3/4/20 at 11:21 A.M., the administrator said she expected staff to remove unwanted facial hair from residents. 6. Review of Resident #29's care plan, dated 1/9/20, showed: -Problem: The resident is incontinent at times of bladder; -Goal: Resident will be clean, dry and free of odors; -Approach: The resident will receive hygiene after each incontinent episode; -No documentation of the resident's preference for assistance of staff of the same gender. Review of the resident's progress notes, showed: -On 2/11/20, the nurse called the resident's responsible party and left him/her a message regarding the resident not letting the certified nurses aide (CNA) shower or change him/her. It is now becoming a hygiene problem. Pending call back; -On 2/12/20 at 11:02 A.M., Per the DON, the resident was given a shower last night by a CNA; -On 2/18/20, the resident refused a shower stating resident would like a same gender staff to give a shower. Responsible party returned call and this nurse spoke to him/her regarding resident not allowing anyone to give a shower. The resident will only allow the same gender to give him/her care or a shower and writer explained that the facility has only one same gender CNA working and that he/she is only here sometimes and that is not working for the resident's hygiene. Writer let responsible party know that is not working out for his/her care and hygiene needs. He/she explained that the resident was like that in the last place. Staff told him/her if the facility would have known that, the facility would not have accepted him/her because they would not be able to meet his/her needs. He/she sighed and got upset and said well what do you want me to do? Writer requested they speak to the resident regarding his/her care. Writer explained that the resident may not be able to live at the facility if she/he is not compliant with care. Responsible party talked to the resident and resident agreed to a shower. Observation and interview on 3/2/20, 3/3/20, and 3/4/20, showed: -On 3/2/20 at 1:30 P.M., the resident ambulated down the hall. Resident wore a black, long sleeved shirt and blue pants. At 6:07 P.M., the resident lay in bed with his/her eyes closed. The resident wore a black, long sleeved shirt and blue pants; -On 3/3/20 at 5:15 A.M., the resident lay in bed with his/her eyes closed. He/she wore a black, long sleeved shirt and blue pants. At 7:47 A.M. and 11:48 A.M., he/she sat in the dining room. He/she wore a black, long sleeved shirt and blue pants. He/she had food crumbs on the shirt; -On 3/4/20 at 7:48 A.M. and 9:33 A.M., resident sat in the dining room. He/she wore a black, long sleeved shirt and blue pants. He/she wore a hat. The resident had an odor. He/she confirmed he/she wore the same clothing for the last three days. He/she received assistance from a same gender CNA with the showers. He/she could not remember the last time he/she received a shower. During an interview on 3/4/20 at 10:02 A.M., CNA C said the resident only wanted staff of the same gender to assist with the showers. CNA K would assist the resident; however CNA K has not worked in the facility for a while. Since the resident was admitted to the facility, he/she has been very particular with not wanting opposite gender to assist him/her. If there were no staff of the resident's gender to assist him/her, staff would try cueing. The resident was able to wash his/her own body, but needed someone to tell him/her to do it. During an interview on 3/4/20 at 11:40 A.M., the administrator said showers sheets are documented and placed into a folder. The former DON would follow up if there were issues, but there were no follow ups since the former DON left in February. The resident does not allow staff of the opposite gender to assist with his/her showers. The facility had a CNA that could assist the resident, but the CNA has not worked in the facility due to being sick. The other CNAs tried to assist the resident by cueing him/her. They would pull the shower curtain and cue from the other side of the curtain, but it did not work. The resident only felt comfortable with same gender. It is not appropriate for the resident to be un-groomed and to wear the same clothing for days in a row. She would expect staff to address the issue. She would expect it to be care planned as well. The administrator had addressed the issue of staffing and to hire more staff to accommodate the resident's preference. During an interview on 3/4/20 at 11:45 A.M., the social worker said the resident allowed some opposite gender staff to assist with the shower. The resident was given a wash cloth and with cues he/she could do certain things. CNA C is able to assist the resident with the showers now. The social worker spoke to the resident's family and confirmed that the same thing happened at a previous facility. The resident has a preference to only have staff of the same gender shower him/her. Review of the facility's shower schedule, showed: -Resident scheduled on Tuesday evenings. Staff documented same gender only; -Resident scheduled on Thursday evenings. No documentation regarding resident's preference.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice when staff failed to identify, assess, and treat a resident with a history of hemorrhoids (Resident #32). The resident sample was 16. The census was 37. Review of the Resident #32's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/21/20, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated 9/18/19 and in use during the survey, showed: -Problem: Resident is aware of his/her need to void/defecate, but he/she is dependent on staff to assist in the bathroom; -Goal: Resident will be continent of bowel and bladder; -Approach: Bowel and bladder program: Take to the bathroom every two hours. Resident requires assistance with cleaning self after each use of the bathroom; -Problem: Resident requires staff assistance with activities of daily living related to poor balance, strength and memory; -Goal: Resident is to actively participate in activities of daily living (ADLs); -Intervention: Resident requires staff assistance with locomotion, wheelchair for longer distances, independent for shorter distances; -Resident requires one staff with gait belt to transfer from surface to surface; -Resident requires one staff to provide hygiene after use of bathroom; -Resident requires one staff to assist with repositioning in bed every two hours. -No documentation of the resident's history of hemorrhoids. Review of the resident's physician's orders [REDACTED]. Special Instructions: apply daily as needed to bleeding Hemorrhoid as needed (PRN); -An order, dated 7/13/19, for Senna plus (stool softener) tablet, 8.6-50 milligram (mg). One tablet twice a day. Review of the resident's Medication Administration Record [REDACTED]. Review of the resident's medical record, showed Proctozone-HC cream last administered on 7/13/19. Review of the resident's progress notes, showed no documentation of the resident's hemorrhoids or assessment of the resident's skin. Review of the resident's skin assessments, dated 1/13/20, 2/13/20, and 2/26/20, showed no documentation of hemorrhoids. Observation and interview on 3/2/20, showed: -At 8:55 A.M., resident sat in a wheelchair near the nurse's station. Resident began to yell out several times. Certified Nurse Aide (CNA) G asked the resident if he/she needed to go to the bathroom. CNA G transported the resident to the bathroom outside the nurse's station; -At 8:59 A.M., the resident yelled from inside the bathroom. With the bathroom door closed, he/she was heard at the nurse's station, approximately 15 feet from the entrance to the bathroom; -At 9:00 A.M., CNA G transported the resident out of the bathroom. CNA G said the resident had hemorrhoids and when he/she had a bowel movement, it hurts him/her. Now that the resident went to the bathroom, he/she is fine; -At 2:17 P.M., the resident heard moaning from his/her room. During an interview on 3/4/20 at 8:34 A.M., CNA H said the resident had hemorrhoids. He/she yells out the same time every morning because that was when he/she needed to use the bathroom. The resident had some sort of cream for them. Sometimes he/she has trouble going to the bathroom, so staff gives him/her prunes. CNA H did not know if the resident had large stools; however, he/she saw the resident's hemorrhoids. The resident's buttocks looks painful. There is redness and a cluster of hemorrhoids. He/she had a history of [REDACTED].M., the administrator said skin assessments are completed on a weekly basis. She was not aware if the resident had hemorrhoids, but she would expect staff to document it on the skin assessment and progress notes. She would expect the physician to be contacted. She would expect staff to follow physician's orders [REDACTED].
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents at risk to develop pressure ulcer/injury (injury to skin and underlying tissue resulting from prolonged pressure on the skin) did not develop a facility acquired pressure injury, and failed to ensure timely assessment and treatment of [REDACTED].#32). The facility also failed to ensure an existing pressure injury was maintained with the ordered treatment in place (Resident #9). The facility identified three residents with existing pressure injuries, two residents were included in the sample. The census

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FIESER NURSING CENTER	404 MAIN STREET FENTON, MO 63026

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) was 37. 1. Review of the undated skin ulcer/wound policy, showed: -Policy: All caregivers are responsible for preventing, caring for and providing treatment for [REDACTED]., resident refusal, cognitive impairment, urinary and bowel incontinence, poor nutrition and history of a healed pressure ulcer; -Assessment: A resident's risk may increase due to an acute illness or condition change such as an infection or exacerbation of an underlying condition that may require additional assessment. It is recommended to repeat a risk assessment if the resident has a significant change in condition. Licensed staff will complete a head to toe skin assessment weekly and as needed (PRN). The skin assessment will be documented on a skin assessment form. Any unusual findings will be documented on the form with a follow up note in the nurse notes further describing the area of concern; -Staff will institute a plan for any resident who has potential for skin breakdown or whose condition is deteriorating, this may include turn and reposition every two hours, pressure reduction surfaces for beds and wheelchairs, floating areas of concerns for heels, separate areas of the body with pillows, use of elbow or heel protectors, promotion of clean, dry and well moisturized skin, avoid powders, follow dietary recommendations; -Nurse aides will complete body audits at least weekly with bathing opportunities. The audits are turned into the charge nurse to review for changes in the skin condition. If the nurse assess and determines there is a skin condition present, the treatment protocol will be followed; -Encourage residents to change position frequently and ambulate as capable; -Incontinent residents will be checked and changed PRN; -Nurse aides will report any clothing, shoes, braces and splints that may not be fitting properly to the supervisor or nurse; -Treatment protocols: Consult wound care providers when appropriate. Until wound care providers can assess and order treatment, the following techniques maybe employed: -For non-open areas of concern or areas covered with stable eschar (dry dead tissue) apply skin prep (protective skin barrier) daily and use preventative measures. On areas where skin prep is not appropriate, such as the buttocks, moisture barrier cream is adequate; -For open areas the treatment is determined based on tissue type and drainage: -For moderate to heavily draining wounds, calcium alginate (absorbent dressing) is appropriate. Cover the area with a secondary dressing, change PRN for soiling and drainage; -For lightly exudating (draining) wounds, cover the wound with a non-stick dressing and change PRN; -For wounds that have slough (moist dead tissue) or unstable eschar is present, a debridement (remove dead tissue) agent is required. The treatment should be changed daily and PRN for soilage and drainage; -For deep or tunneling wounds, fill the open space with calcium alginate or other packing agent and loosely pack the wound. Cover with a secondary dressing; -All orders must be approved by a physician within 24 hours of discovering the open area or the change in the treatment; -Nurses may not diagnose, just describe; -Measurements must be completed weekly by the same licensed person when at all possible; -At the time a skin issue is discovered it must be measured. Wounds are three dimensional, therefore length, width and depth must be documented if using measuring instrument. It is acceptable to measure using common household objects (dime size, quarter size) until actual measurements can be obtained per facility protocol; -If a reddened area is identified, the nurse should assess if the area is blanching (skin will appear white when pressure is applied and return to pink when pressure is released). If the skin does not blanch, the nurse should retest in 30 minutes. If the skin then blanches, it is not a skin concern. If the skin does not blanch, then the area should be captured on the skin licensed body audit; -A wound assessment should be documented in the nurse notes (or other documentation location) with each dressing change; -It is recommended to chart on a Treatment Administration Record (TAR) or other location that the dressing is intact every shift that a dressing change is not performed. 2. Review of the Resident #32's quarterly Minimum Data Set (MDS), a federally assessment instrument used by facility staff, dated 1/21/20, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated 9/18/19, and in use during the survey, showed: -Problem: The resident is at risk for pressure ulcers and requires staff assistance to reposition; -Goal: Resident will remain free of pressure ulcers and moisture associated skin damage; -Approach: Therapy placed a Roho cushion (pressure relieving device) in the wheelchair. The resident will be repositioned every two hours. The resident will have skin assessment weekly by a licensed nurse. Staff to provide a pressure reducing mattress on the bed for comfort. Review of the resident's skin assessment, dated 1/13/20, 2/13/20, and 2/26/20, showed no pressure ulcers. Review of the resident's Braden assessment (evaluate risk of developing pressure ulcer), dated 1/28/20, showed 12 points (12 points is high risk of developing pressure ulcers). Review of the resident's Physician order [REDACTED]. Observations on 3/2/20 and 3/3/20, showed: -On 3/2/20 at 8:55 A.M., the resident sat in the wheelchair near the nurse's station. The resident yelled out several times. Certified Nurse Aide (CNA) G asked the resident if he/she needed to go to the bathroom. CNA G transported the resident to the bathroom outside the nurse's station. At 11:10 A.M., the resident sat in the wheelchair in the hallway outside his/her room; -On 3/2/20 at 1:00 P.M. and 1:59 P.M., the resident sat in the wheelchair in his/her room. His/her head down and eyes closed. At 2:17 P.M., the resident sat in the wheelchair in his/her room. He/she was heard moaning from the hall. At 2:57 P.M., the resident sat in the wheelchair in his/her room. At 5:30 P.M. and 6:06 P.M., the resident sat in his/her wheelchair in the dining room during meal service; -On 3/3/20 at 5:17 A.M., the resident sat in the dining room in the wheelchair. At 10:43 A.M., the resident observed in the dining room during activity. He/she continued to call out, oh and ow. The resident stayed in the dining room till lunch. At 12:59 P.M., the resident sat in the dining room during meal service. Observation and interview on 3/3/20 at 1:45 P.M., showed Licensed Practical Nurse (LPN) J assessed the resident's skin. The resident's left bottom of the buttocks had two superficial open areas. LPN J measured one area at 0.4 centimeters (cm) x 0.5 cm. A smaller separate open area measured 0.2 cm x 0.3 cm, the center of the wound noted to be pink and no drainage. The resident's right great (big) toe intact skin with non-blanchable redness, approximately 1 cm round. Bilateral heels are red-blanchable. LPN J said the heels are soft. LPN J said the CNA should report all open areas to the charge nurse. Once the nurse is made aware of the wound the nurse will get a measurement and call the doctor with a description of what the wound looked like then they follow what the doctor says. Usually the doctor will order wound care clinic to see the resident. Staff will call the wound clinic and the wound clinic will send out a wound care registered nurse (RN) to come and evaluate the wound and obtain initial wound care orders. The facility will then follow the wound care clinic orders once the wound had been assessed. During an interview on 3/4/20 at 11:55 A.M., the administrator said skin assessments are completed on a weekly basis. She would expect staff to follow physician's orders [REDACTED]. If staff found an open area, she would expect it to be reported immediately to the nurse. The open area should be assessed and documented in the wound report. 3. Review of Resident #9's quarterly MDS, dated [DATE], showed: -Moderate cognitive impairment; -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated on 12/9/19, showed: -Problem Start Date: The resident has arterial wounds (ulcerations develop as a result of poor blood flow) to both lower legs and swelling that causes draining; -Goal: The resident's legs will remain warm, pale and pulses detectable and skin intact; -Approach: Staff to administer wound treatments as ordered to lower legs, wound physician to assess weekly and change treatment plan if needed and obtain ordered testing for blood flow; -Pressure ulcers to care planned. Review of the resident's progress notes, showed on 1/13/20 a blister noted to the right buttock and to the top of the right and left buttock cleft (fold). Area cleansed and barrier ointment applied. The resident's physician notified and awaiting further orders. Review of the resident's POS, showed an order dated 1/13/20 to apply barrier ointment to the buttocks twice daily. Review of the resident's TAR, dated 1/1/20 through 1/31/20, showed: -An order dated 1/13/20 and discontinued on 1/19/20 to apply [MEDICATION NAME] (barrier ointment) to open sores on the buttocks and top of the thigh folds twice daily. All days initialed as completed; Review of the nurse skin assessments, showed: -On 1/16/20 at 3:10 P.M., showed: -Skin history: No new areas of concern observed by or reported to the nurse; -No history of pressure ulcer in the last six months; -Skin color: normal, no signs of inflammation or infection, no wounds; -Current treatment: lotion PRN, major wound to both lower legs with treatment and A & D ointment PRN; -Plan: continue current plan and the resident is seen by the wound clinic; -No assessment of buttock wounds completed on 1/13/20. Further review of the resident's TAR, dated 1/1/20 through 1/31/20, showed: -An order dated 1/19/20 and discontinued on 2/27/20 to cleanse the buttocks with soap and water, pat dry, apply [MEDICATION NAME] dressing (non-adherent dressing), cover with Dermafilm [MEDICATION NAME] wound dressing (occlusive dressing). Change daily and PRN if soiled. All scheduled days noted as completed. Further review of the nurse skin assessments, showed: -On 1/23/20 at 1:43 P.M.: -Skin history: two quarter size sores to the buttocks; -No history of pressure ulcer in the past six months; -Skin color: normal, no signs of inflammation or infection, no wounds; -Current treatment: [MEDICATION NAME] to buttocks with dressing; -Plan: continue current treatment. -On 2/10/20 at 8:48 A.M.: -Skin history: quarter size ulcer to the right buttock and nickel size area to the left buttock; -History of a pressure ulcer in the last six months: yes- no description provided; -Skin color: normal, no signs of inflammation or infection, stage 1 pressure ulcer (non blanchable pressure ulcer with skin intact) to the buttocks; -Current treatment: no selection; -Plan: continue current plan. -On 2/11/20 at 2:47 P.M.: -Skin history: Three small sores on buttocks that are penny size; -History of pressure ulcer in the last six months: yes- no description provided; -Skin color: normal, no signs of inflammation or infection, stage 2 pressure ulcer (partial thickness wound) to the buttocks; -Current treatment: no

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) selection; -Plan: continue current plan. Review of the resident's wound clinic visit note, dated [DATE], showed: -Problem location: wound to the right buttock that measured 0.5 cm x 1.5 cm x 0.0 cm; -Remove the old dressing, cleanse area with soap and water, apply [MEDICATION NAME] (protective ointment that encourages wound healing) cover with bordered foam dressing. Preform dressing changes three times a week and PRN for a month. Review of the resident's electronic POS, showed and order dated 2/27/20, to cleanse buttocks with soap and water, pat dry, apply [MEDICATION NAME], cover with bordered foam dressing. Change daily and PRN for soilage. Review of the resident's TAR, dated 2/1/20 through 2/29/20, showed: -An order dated 1/19/20 and discontinued 2/27/20, to cleanse the buttocks with soap and water. Pat dry, apply [MEDICATION NAME] petroleum dressing. Cover with dermafilm (occlusive dressing) wound dressing, change daily and PRN for soilage. Noted to be completed daily until stop date of 2/27/20; -An order dated 2/27/20 to cleanse the buttocks with soap and water, pat dry, apply [MEDICATION NAME], cover with bordered foam dressing. Change daily and PRN if soiled. All days noted as completed. Review of the resident's TAR, dated 3/1/20 through 3/2/20, showed: -An order dated 2/27/20 to cleanse the buttocks with soap and water, pat dry, apply [MEDICATION NAME], cover with bordered foam dressing. Change daily and PRN if soiled. All days noted as completed. Observation and interview on 3/2/20 at 4:59 P.M., showed the resident lay in bed. CNAs G and F said the resident is often incontinent of urine and may have a red area to his/her buttocks. CNA G said he/she had given personal hygiene to the resident earlier in the day and did not notice any open areas. CNA G and F provided personal hygiene to the resident and assisted the resident onto his/her side and exposed the buttocks. A small pin point open circular area noted to the back of the right thigh fold. The Director of Nursing (DON) measured the open area at 0.3 cm x 0.1 cm, no dressing on the area. CNA G and F applied a dry brief under the resident and secured the brief into place. No wound dressing or barrier ointment had been applied by the DON or nursing staff. During an observation and interview on 3/3/20 at 8:58 A.M., LPN J and the DON entered the resident's room and provided wound treatments to the resident's lower legs. LPN J and the DON assisted the resident onto his/her side and exposed the buttocks. An open area to the right thigh fold remain uncovered, red and clear drainage noted in the wound bed. A secondary open area noted to the left buttock thigh fold approximately the size of a pencil eraser, noted as uncovered and no drainage. The skin noted as red. Neither nurse provided wound measurements to the new open area. The DON said if an open area is discovered, the charge nurse is responsible to call the resident's physician with a description of the wound and obtain orders. The facility uses a wound care clinic to assess and stage all wounds. The wound clinic would be notified of the wound and would come and make and assessment and provide any new orders. The wound clinic comes weekly to the facility. The buttock wounds are related to pressure. If the wounds have an order, the wound treatment should be in place. The nurse should not be signing off on wound treatments if they are not done. CNAs should be examining the resident's skin at all times with care and report any changes immediately to the charge nurse so he/she can assess the area. The charge nurse would then obtain measurements, call the resident's physician for initial orders and document in the resident's record the findings and orders.
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 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 the residents environment remained as free of accident hazards as is possible by failing to ensure medications were secured and not accessible to residents. In addition, the facility failed to ensure proper and safe locomotion techniques for one resident observed to be propelled by staff in a wheelchair (Resident #32). The sample was 16. The census was 37. 1. Review of the facility's medication storage policy, dated 5/2019, showed: -Policy: Medications and biological's are stored safely, securely and properly following the manufacture or suppliers recommendations. The medication supply is only accessible to the licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications; -Procedure: Medication supplies are locked or attended by personnel with authorized access such as the licensed nurse, pharmacist, pharmacist technician, consultant nurses and any individual lawfully authorized to administer drugs. Observation and interview on 3/1/20, showed: -At 1:00 P.M., 13 [MED] pens and 3 [MED] vials were left exposed on top of the nurse medication cart. [MED] pen needles and lancets were accessible and the nurse was not present in the area; -At 1:35 P.M., all [MED] pens, vials and supplies continued to be exposed on top of med cart. No nurse was present; -At 1:43 P.M., the charge nurse approached the nurse medication cart, removed the exposed [MED], lancets and [MED] pen needles and placed the items into the top drawer of the medication cart. During an interview 3/1/20 at 1:48 P.M., Licensed Practical Nurse (LPN) J said [MED] supplies should not be left unattended or exposed to other staff and residents. Supplies should be kept locked and secured on the medication cart. 2. Observation on 3/2/20, showed: -At 8:06 A.M., three [MED] vials, needles and lancets on top of nurse medication cart in the hallway in front of the dining room. No nurse was around. Multiple residents passed the medication cart; -At 8:19 A.M., an LPN spoke to a staff member but walked away, did not approach the nurse medication cart to remove the exposed [MED] and the supplies from the top of the cart; -At 8:26 A.M., no nurse within view of the nurse medication cart. The [MED] and [MED] supplies remained exposed. During an interview on 3/4/20 at 8:25 A.M., the Director of Nursing (DON) and Administrator said the all [MED] and supplies should be secured on the medication cart. Medications should never be exposed. Exposed medications and supplies could allow residents and staff to access medications that are not ordered for them. Licensed nurses are the only staff that should have access to the [MED] and its supplies. 2. Review of the Resident #32's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/21/20, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated 9/18/19 and in use during the survey, showed: -Problem: Required staff assistance with activities of daily living related to poor balance, strength and memory; -Intervention: Required staff assistance with locomotion.Wheelchair for longer distances, independent for shorter distances. Observation and interview on 3/4/20 at 8:29 A.M., showed the resident sat in the wheelchair. He/she was propelled to the scale. Staff asked the resident to raise his/her feet and the resident continued to say ow. He/she did not raise his/her feet while being propelled. The resident was weighed in the wheelchair and the staff transported the resident out of the room. Staff asked the resident to raise his/her feet during the transfer. The resident said, no and he/she did not raise his/her feet. There were no foot pedals on the wheelchair. Staff began to transport the resident down the hall as his/her feet dragged on the floor. The resident began to yell out ow as he/she was transported down the hall. The resident yelled out crazy. Staff transported the resident to his/her room where the yelling stopped. During an interview on 3/4/20 at 11:55 A.M., the administrator said she would expect staff to assess the resident's wheelchair to determine if it needed foot pedals. Foot pedals would be easy to add on to the wheelchair. She would expect staff to stop and assess the resident if he/she was yelling out. It was not appropriate for staff to continue to transport the resident while their feet dragged on the floor.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the services of a Registered Nurse (RN) for eight consecutive hours per day, seven days a week. In addition, the facility failed to designate a registered nurse to serve as the director of nursing on a full time basis. The deficient practice had the potential to affect all residents. The facility census was 37. Review of the facility staffing sheets, dated 3/1 through 3/4/20, showed the facility did not have an RN at least eight hours a day. During an interview on 3/2/20 at 1:54 P.M. and 5:46 P.M., the administrator said the facility hired an RN consultant to come to the facility for four hours a week. The administrator was under the impression that the facility did not need a full time RN because the facility was an Intermediate Care Facility (ICF), so the consultant hours would fulfill the required RN hours. The former Director of Nursing (DON) was an RN; however, he/she left the faciity on [DATE]. The facility has another RN; however, he/she works as needed (PRN). The administrator confirmed that the facility had been without an RN since 2/17/20. The current DON is a Licensed Practical Nurse (LPN).
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.**

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F 0730 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 6) Based on interview and record review, the facility failed to have a system in place to ensure certified nurse assistants (CNAs) received the required 12 hours of in-service training based on performance reviews, for six of six CNA employee files reviewed who worked in the facility more than one year. The facility showed they currently had six CNAs, who worked in the facility more than one year. The census was 37. 1. Review of CNA A's training record, showed the following: -Date of hire, 11/16/15; -Total hours of training completed for the last full year of employment, 3 hours. 2. Review of CNA B's training record, showed the following: -Date of hire, 4/20/12; -Total hours of training completed for the last full year of employment, 3 hours. 3. Review of CNA C's training record, showed the following: -Date of hire, 11/4/14; -Total hours of training completed for the last full year of employment, 3 hours. 4. Review of CNA D's training record, showed the following: -Date of hire, 1/5/04; -Total hours of training completed for the last full year of employment, 3 hours. 5. Review of CNA E's training record, showed the following: -Date of hire, 7/26/17; -Total hours of training completed for the last full year of employment, 3 hours. 6. Review of CNA F's training record, showed the following: -Date of hire, 8/10/16; -Total hours of training completed for the last full year of employment, 3 hours. 7. During an interview on 3/2/20 at 1:54 P.M. and 4:36 P.M., the administrator confirmed she and the Director of Nursing (DON) were responsible for ensuring all CNAs had their required 12 hour training. The administrator was aware there was an issue with the CNA 12 hour training. She was unable to find training logs and some did not have hours on it. She was not aware that the CNA 12 hour training was calculated from anniversary date to anniversary date.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Post nurse staffing information every day.** Based on observation, interview, and record review, facility staffed failed to post required nurse staffing information, which included the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift, on a daily basis. In addition, the facility failed to maintain 18 months of staffing. The facility census was 37. 1. Observation on 3/1/20 at 1:08 P.M., 3/2/20 at 12:35 at P.M., 3/3/20 at 12:00 P.M., and 3/4/20 at 3:00 P.M., showed staff did not post required nurse staff information, to include the total number of staff and the actual hours worked by both licensed and unlicensed nursing staff directly responsible for resident care, per shift. The staff names were documented in place of the number of hours. During an interview on 3/4/20 at 12:14 P.M., the administrator said she would expect the number of actual hours worked by licensed and unlicensed staff to be posted, not the names of the staff. 2. Review of the facility's staffing sheets, dated September 2018 through February 2020, showed: -Staffing from 1/1/19 through 6/20/19, with no documentation of actual hours worked by licensed and unlicensed staff; -Staffing from 11/25/19 to 12/16/19, with no documentation of the facility name; -The staffing sheets not provide for staffing from 9/1/18 through 12/31/18, 6/21/19 through 11/24/19, and 12/17/19 through 2/29/20. During an interview on 3/3/20 at 11:30 P.M., the administrator said she did not have the required 18 months of staffing. She provided what she could however, she did not know if the previous administrator maintained 18 months of staffing.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure as needed (PRN) [MEDICAL CONDITION] medications were re-evaluated after 14 days of use for two of six residents investigated for unnecessary [MEDICAL CONDITION] medication review (Residents #22 and 19). The census was 37. Review of the facilities Summary of Unnecessary and [MEDICAL CONDITION] Medications Policy, dated 11/26/19, the policy failed to address reevaluation of as needed [MEDICAL CONDITION] medications. 1. Review of Resident #22's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/1/19, showed: -Cognitively intact; -[DIAGNOSES REDACTED]. Review of the resident's electronic physician order [REDACTED]. Review of the pharmacy monthly medication review, note to attending physician/prescriber, dated 1/28/20, showed: -Phase 2 of the Center for Medicare and Medicaid services (CMS) final rule states that PRN [MEDICAL CONDITION] drugs are limited to a 14 day supply. In order to extend the PRN order beyond 14 days the prescriber must document the rationale for extending the duration in the medication record and indicate duration for a PRN order. Resident has a PRN order for [MEDICATION NAME] 1 mg every eight hours PRN, recommend the medical doctor review the medication order and document rationale along with specific stop date and/or indicated duration in the medical record. Hand wrote on the form was a note to refer to psych, dated 2/4/20. No further clarification or documentation of rationale completed by the physician. 2. Review of Resident #19's annual MDS, completed by facility staff, dated 12/1/19, showed the following: -Cognitively intact; -Behaviors included, verbal and physical towards others, rejection of care, and wandering; -[DIAGNOSES REDACTED]. Review of the resident's electronic physician's orders [REDACTED]. (No end date specified). 3. During an interview on 3/4/20 at 9:00 A.M., the administrator said PRN [MEDICAL CONDITION] medications should have a time limit of 14 days. The nurse should call the medical doctor to get a new order if the medication is needed longer. The doctor should have been called after 14 days, and was not aware the medication ordered as open ended.
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.** Based on interview and record review, the facility staff failed to inspect exit doors and smoke barrier doors in accordance with NFPA. The failure to inspect the doors could result in equipment failure in the event of an emergency and delay evacuation. This failure has the potential to affect all facility occupants. The facility had a capacity of 60 with a census of 37 residents at the time of the survey. Review of the facility's inspection, testing and maintenance records dated 3/19 through 3/20, showed the records did not contain detailed documentation of inspection and testing of the exit doors or smoke barrier doors. During an interview on 3/2/20 at 11:00 A.M., the maintenance supervisor said he inspected the doors monthly and put a check mark under fire doors. He checked to make sure they close and don't have any openings. During an interview on 3/2/20 at 2:55 P.M. the administrator said the maintenance staff were responsible for the maintenance of doors. She did not know the maintenance supervisor was not performing a complete inspection of the doors. Review of NFPA 101, 2012 Edition showed the following: -19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. -7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7; (2) Door assemblies in exit enclosures; (3) Electrically controlled egress doors; (4) Door assemblies with special locking arrangements subject to 7.2.1.6. -7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. -7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. -7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. NFPA 105, 2010 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced. 5.2.1.4 Tin clad and Kalamein doors shall be inspected regularly for dry rot. 5.2.1.5 A written record shall be maintained and shall be made available to the authority having jurisdiction. 5.2.1.6 Records shall be maintained for not less than 3 years.

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	26A490	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure expired food was removed and food was dated when opened. In addition, the facility failed to ensure a fan used in the kitchen was free of dirt and debris. These deficient practices had the potential to affect all residents who ate at the facility. The census was 37. Observation on [DATE] at 12:51 P.M., [DATE] at 1:53 P.M., and [DATE] at 2:54 P.M., showed: -One can of 50 ounce (oz.) of chicken with rice soup, with a use by date of [DATE]; -Ten cans of 50 oz. of chicken with rice soup, with a use by date of [DATE]; -Dust and debris on the double fan inside the walk-in cooler; -Wrapped sliced Swiss cheese with a date of [DATE]. Observation on [DATE] at 12:51 P.M., [DATE] at 1:53 P.M., and [DATE] at 2:54 P.M., showed a large fan inside the kitchen with a buildup of dust and debris. The fan was turned on as staff prepared food in the kitchen. During an interview on [DATE] at 2:54 P.M., the dietary manager said she is responsible for ensuring expired cans were removed from the storage room, but the chicken with rice soup is not served very often. She would expect staff to call maintenance to clean the dust and debris off the fans inside the walk in cooler and inside the kitchen. The wrapped cheese should have a date that is legible. The dietary manager confirmed that the wrapped cheese had a date of [DATE] and it was good for 30 days. The dietary manager was asked if it was past 30 days and if the Swiss cheese should be thrown out. She said not necessarily because it was still being used for sandwiches.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interview and record review, the facility staff failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents by failing to include Registered Nurse (RN) personnel needed to ensure sufficient number of qualified staff are available to meet each resident's needs during day-to-day operations and emergencies. In addition, the facility assessment failed to include a facility-based & community-based risk assessment, utilizing an all-hazard approach. The facility census was 37. 1. Review of the Facility Assessment, dated as reviewed and updated by the facility on 2/28/20, showed staff: Licensed Nurse: RN, Licensed Practical Nurse (LPN), providing direct care and/or charge duties: -Director of Nursing (DON): One DON, LPN full-time; -RN or LPN charge nurse: One licensed nurse for each shift; -Further review of the Facility Assessment, showed no documentation of required RN coverage for eight hours a day, seven days a week and/or requirement for the DON to be an RN. During an interview on 3/2/20 at 1:54 P.M. and 4:36 P.M., the administrator said she was under the impression that she only needed an RN for four hours a week because she had believed the facility to be an Intermediate Care Facility (ICF). She would expect the Facility Assessment to include the accurate number of required nurse staff. 2. Further review of the Facility Assessment, showed refer to the facility hazardous vulnerability and emergency preparedness (EP) plan as it pertains to risk assessment. Review on 3/2/20 of the EP plan binder, located at the nurses desk, showed only documentation of contracts for specific residents who would be picked up in case of an emergency. During an interview on 3/2/20, the administrator said she only started working at the facility three months ago. She could not find the EP manual and believed the former administrator took it when he/she left.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an effective quality assurance (QA)/quality assurance performance improvement (QAPI) program when they did not implement appropriate interventions to correct on-going, systemic issues. The sample was 16. The census was 37. 1. Review of the facility's QA/QAPI program, updated on [DATE], showed: -Purpose: Vision statement: To provide a homelike environment where people are cared for attentively, [MEDICATION NAME] and with dignity and respect; -Mission statement: To be home for people in our community. The facility is committed to providing them with the necessary skills, insight, socialization and health/wellness habits in order to attain the highest level of functioning in the least restrictive environment; -Guiding values or principles: The written plan for the facility will identify and address areas that need improvement in order to ensure the best quality of life for the people in the community. All employees will participate in ongoing QAPI efforts which support our mission by committing to provide resident of our community with the necessary skills, insight, and socialization and health/wellness habits in order to obtain the highest level of function in the least restrictive environment. The administrator will assure that the QAPI plan is reviewed minimally on an annual basis by the QAA committee. Revisions will be made in the plan ongoing, as the need arises, to reflect current practices within our community. These revisions will be made by the QAA committee. Revisions will be communicated as they occur to residents, families and staff through meetings and newsletters; -Scope: Our community provides services to impact the clinical care, quality of life and necessary skills, insight, socialization, health and wellness habits in order for the to attain the highest level of functioning they need to be in the least restrictive environment; -The QAPI plan will include policies and procedures used to: -Identify problems and opportunities for improvement; -Use data to monitor our performance; -Use resident, staff and guardian input; -Set goals for our performance measurements; -Analyze causes of problems and adverse events; -Develop corrective actions improvement activities; -Governance and leadership: -Responsibility and accountability: The administrator has the responsibility and held accountable to the corporation for ensuring QAPI is implemented throughout the community. QAPI activities and discussion will be a part of the weekly risk meetings that the administrator and all key staff will attend. The administrator will be responsible for assuring all QAPI documentation is kept for review by the corporation or other licensing agencies. 2. Review of the annual survey results for the prior survey dated 4/10/19 and the current survey dated 3/4/20, showed the facility cited F727 for the failure to use the services of a registered nurse (RN) for at least eight consecutive hours a day, seven days a week. 3. Review of the facility's QAPI binder on 3/4/20 at 10:41 AM, showed a Performance Improvement Project (PIP) for Minimum Data Set (MDS, a federally mandated assessment instrument required to be completed by facility staff) and resident care plans not being completed in a timely manner. The PIP was dated 2/26/20 and did not list staff who attended or signatures. The QAPI binder did not address staffing or RN coverage. 4. During an interview on 3/4/20 at 1:15 P.M., the Administrator and Director of Nursing said that the facility has not had a QAPI/QAA meeting since November 2019. The PIP for the MDS and care plans had been recently identified and the facility did not have an operational QAPI/QAA program in place. The members of the QAPI should be the administrator, medical director, director of nursing (DON), various nursing staff, dietary services and the social worker. The facility has started to conduct daily standing rounds at the nurse's station to discuss changes or resident status.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide documentation showing the quality assurance and assessment (QAA) committee met quarterly for a quality assurance performance improvement (QAPI) meeting. This deficient practice had the potential to affect all residents. The census was 37. Review of the facility's QA/QAPI program, updated on [DATE], showed: -Purpose: Vision statement: To provide a homelike environment where people are cared for attentively, [MEDICATION NAME] and with dignity and respect; -The QA/QAPI program did not specify the frequency of the QAPI meetings. During an interview on 3/4/20 at 1:15 P.M., the administrator and Director of Nursing said that the facility has not had a QAPI/QAA meeting since November 2019. The Administrator planned on scheduling a QAPI/QAA meeting sometime for the month of

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F 0868 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 8) March 2020. She needed to hear back from the medical director for scheduling so he could attend.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to follow acceptable infection control practices to prevent the spread of infection for one resident who was on isolation precautions (Resident #88) and one resident of the 16 sampled residents by not keeping the tubing for a high humidity oxygen concentrator from resting on the floor (Residents #20). The facility failed to take soiled linen to the laundry room in the designated laundry barrels. In addition, they failed to follow their own policy on how to disinfect the glucometer (machine used to check blood sugars) machine after use/between residents. The census was 37. Review of the facility Standard and Transmission Based Precautions Policy, showed: -Standard Based Precautions will be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume all blood, body fluids, secretions and excretions (except sweat), non-intact skin and mucous membranes may contain infectious agents; -Staff will be trained in various aspects of Standard Precautions to ensure appropriate decision-making in various clinical situations; -Signs, the facility will implement a system to alert staff and visitors to the type of precaution the resident requires; -Linen: Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and provides transfer of microorganisms to other residents and environment; -Laundry: Contaminated laundry bagged at the location where it is used and is not sorted or rinsed except in designated areas of dirty utility room and laundry area; -Contaminated laundry is placed and transported in bags that are labeled with the biohazard symbol or that are red in color. These bags are stored in the dirty laundry area until the linen can be washed. Whenever this laundry is wet and presents a reasonable likelihood that the bag will soak through or leak, the laundry is placed and transported in another bag that prevents fluid from leaking to the exterior. These bags are stored in the dirty laundry until the linen can be laundered; -Laundry workers are to wear protective gloves and other appropriate personal protective equipment to prevent occupational exposure during handling or sorting. -Contact Precautions: In addition to Standard precautions, implemented contact precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions are necessary will be evaluated on a case by case basis; -Examples of the infections requiring contact precautions include, diarrhea associated with [MEDICAL CONDITION]; -During report, shift change and word of mouth from supervisor will inform all employee of precautions. The facility will also ensure the resident's care plan and care communication system indicates the type of precautions implemented for the resident. 1. Review of the facilities infection/antibiotic control log showed: -Resident #88, list on the log for the months of February and March 2020; -GI (gastrointestinal) checked; -Under the section labeled symptoms, [MEDICAL CONDITION], ([MEDICAL CONDITION]., a bacteria that causes diarrhea and [MEDICAL CONDITION] (an inflammation of the colon) wrote in; -Antibiotic was started [DATE] and to be completed [DATE]. Review of the facilities Infection Summary Report: dated 12/1/19 through 3/1/20, showed: Source of Infection: -GI zero, marked for acquired in house, admitted with, and for total; -Number of residents on isolation at any time during the period reported on was zero. Review of the resident's electronic medical record showed: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/2/20, showed: -Severe cognitive impairment. Review of the resident's electronic physician order [REDACTED]. Review of the resident's care plan, used during survey, showed as of 3/4/20, no mention of [MEDICAL CONDITION] or isolation precautions. Review of the resident's progress notes showed: -On 2/22/20, the physician was notified the resident had mucous and very foul smelling odor in stool. A stool sample was ordered; -On 2/25/20, the family was notified the resident was positive for [MEDICAL CONDITION] and antibiotic therapy continues; -On 2/27/20, isolation precautions were in place; -On 3/2/20, the resident is free of symptoms for three days and taken off isolation. Observation on 3/1/20 at 12:30 P.M., showed the resident's room had one red and one yellow trash bag full, open and sat on the floor next to the wall. A yellow trash bag sat on a rubber type trash can, also had items in the bag. A red bag inside a trash can with no lid on the side of the yellow trash bag sat on the rubber type trash can. There was a yellow gown wadded up on the floor. No sign was placed on the door; -Observation and interview on 3/1/20 at 1:10 P.M., showed the resident sat in the lounge room by the nurse's station, and ate his/her lunch which was served on styrofoam tray with styrofoam cups. The Director of Nursing (DON) said the kitchen served the resident his/her meal on styrofoam because he/she had [MEDICAL CONDITION]. Further observation at 3:00 P.M., showed the resident sat in the doorway of his/her room. Trash bags sat on the floor. At 4:00 P.M., the resident lay in bed, his/her eyes closed. The trash bags that had sat on the floor had been removed. There are two small trash cans along the wall. One trash can had a yellow trash bag and the other trash can had a red trash bag, no lids were present on the trash cans. Above the trash can on the wall was a sign that read trash only. No sign was on the door or outside the door. On the handrail was a package of open isolation gowns and a box of gloves; -Observation on 3/2/20 at 7:14 A.M., showed the resident up in his/her chair and sat in the doorway to his/her room. A package of gloves and gowns sat on the handrail in hall outside the resident's room. No sign was placed on the door. At 1:40 P.M., the trash cans in the resident's rooms had been changed to small trash cans with lids. Inside each trash can was a plastic trash bag. One had a red trash bag, the other had a yellow trash bag; -Observation on 3/3/20 at 10:49 A.M., showed the red trash can in the residents room full with the lid that hovered approximately 3 to 4 inches above the trash can, because it was full. During an interview on 3/4/20 at 7:20 A.M., Licensed Practical Nurse (LPN) J said the isolation precautions are communicated to the staff through report. The staff would also know the resident was on isolation precautions because his/her room changed. The red trash bags are for bio-hazard trash and the yellow trash bags are for linens. The certified nurse assistants (CNAs) are responsible for removing the trash bags from the room. LPN J said as of 3/2/20, the resident is no longer on isolation because he/she had formed stool. During an interview on 3/4/20 at 9:00 A.M., the administrator said there should be a sign on the door that to indicate to see the nurse before entering, for any resident who is on isolation precautions. 2. Review of Resident #20's annual MDS, dated [DATE], showed: -Cognitively intact; -One staff assist for transfer, dressing and toileting; -[DIAGNOSES REDACTED]. Review of the resident's ePOS, dated 3/1/20 through 3/31/20, showed; -An order dated 11/29/19, for oxygen, at 2-3 Liters per nasal cannula, for shortness of breath, as needed; -An order dated 12/4/19, to change oxygen tubing and humidifier bottle every week on Sundays when in use. Observation and interview on 3/1/20 at 1:48 P.M., showed an oxygen concentrator sat against the wall in the resident's room. The resident said he/she rarely used oxygen, it is used only when he/she needs it. The tubing and nasal cannula hung from the front of the concentrator, uncovered. Observation of the resident's room, showed on 3/2/20 at 8:06 A.M., 3/3/20 at 10:30 A.M., 3/4/20 at 8:20 A.M., the oxygen concentrator sat against the wall, the tubing and nasal cannula hung from the front of the concentrator, uncovered. During an interview on 3/4/20 at11:19 A.M., the administrator said oxygen tubing should be bagged and dated. During an interview on 3/4/20 at 10:54 A.M., the administrator said soiled items should be in a bag, to prevent cross contamination and bins have lids and should be kept covered. Residents who are on isolation precautions, should have a sign on the door directing visitors and staff to go to nurse's station for further information. There should be no open bags in the resident's room, once full, they should have been disposed in the biohazard room. 3. Observation of the facility staff, showed: -On 3/2/20 at 8:08 A.M., two unidentified staff walked down the 200 Hall and carried small laundry baskets and the laundry overflowed and pressed against their uniforms; -On 3/4/20 at 10:58 A.M., CNA G handled unprotected, stained soiled linen in his/her arms and walked down the hall into the bathroom across from the nurse's station. During an interview on 3/4/20 at 8:13 A.M., the laundry manager said soiled laundry is transported to the laundry room in barrels. Laundry should go from resident's personal laundry baskets to barrels. Staff should never carry laundry/linens due to infection control, it can have anything on it, and laundry/linens need to go into barrels. 4. Review of the facilities Blood Glucometer Disinfecting Policy, dated 3/15 showed: -Purpose: To prevent the spread of infection; -Equipment: Approved wipes with 10% bleach or comparable product; -Guidelines: Clean the blood glucose meter prior to using with approved wipes with 10% bleach or comparable product. Place on clean field and let air dry according to manufactures directions. Do not touch the clean

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 9) field with gloves including the test port. Glucometer may be wrapped in another wipe and store. During an observation on 3/2/20 at 10:50 A.M., showed LPN I wiped down the glucometer with a disinfecting wipe. The label on the container of the disinfecting wipes read kills 99% of bacteria in 15 seconds, kills cold and flu virus-E.coli and salmonella; bleach free. After LPN I cleaned the glucose meter, LPN I sat the glucose meter down on top of the medication cart. the LPN did not place a barrier between the glucose meter and the top of the medication cart. LPN I performed the glucose testing, cleaned the glucose meter with a disinfecting wipe, then he/she sat the glucometer back down on the top of the medication cart. No barrier was placed between the glucometer and the top of the medication cart. During an interview on 3/4/20 at 1:12 P.M., the director of nursing (DON) said she was unaware the disinfecting wipes label read bleach free. The facility had just changed to those disinfecting wipes, and staff should put a barrier down between the glucometer and the top of the medication cart. The administrator said staff should use disinfecting wipes with 10% bleach.