| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445439 | A. BUILDING _____ B. WING _____ | 03/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| MT JULIET HEALTH CARE CENTER | 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0550<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review, observation, and interview, the facility failed to maintain dignity for 1 of 5 residents (Resident #18) reviewed who required an indwelling urinary catheter. The findings include: Review of the medical record showed Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Physician order [REDACTED].#18, dated 3/3/2020, showed, .22 FR (french) (size of the catheter) 30 cc (cubic centimeters) indwelling urinary catheter . Review of Resident #18's Care Plan dated 12/9/2019 showed, .keep drainage bag covered to promote dignity . Observations in the resident's room on [DATE] at 11:09 AM and 3:20 PM showed Resident #18's indwelling urinary catheter bag was hanging on the left side of bed without a privacy cover. During an interview on [DATE] at 11:10 AM, Licensed Practical Nurse #3 confirmed Resident #18's indwelling urinary catheter bag was not placed in a privacy cover. During an interview on 3/3/2020 at 4:43 PM, the Director of Nursing stated that her expectations were for the indwelling urinary catheter bags to be placed in a privacy cover at all times to promote dignity of the residents. She confirmed Resident #18's indwelling urinary catheter bag was not placed in a privacy cover. |
| F 0600<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility policy review, medical record review, facility documentation review, and interview the facility failed to ensure 1 of 38 residents (Resident #33) was free from abuse placing the resident in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) when Resident #33 sustained a left humerus (long bone that extends from the shoulder to the elbow) fracture during an attempted transfer, without a mechanical lift, on 10/22/2019. The facility failed to ensure Resident #33 was free from Psychosocial harm as evidenced by Resident #33 had increased anxiousness, cried when she talked about the incident that occurred on 10/22/2019, was fearful of Certified Nursing Assistant (CNA) #1, and received psychosocial therapy and medication changes. The Administrator, Director of Nursing (DON), and Regional Nurse Consultants were notified of the Immediate Jeopardy (IJ) on [DATE] at 7:31 PM in the Administrator's office. The facility was cited Immediate Jeopardy at F-600. The facility was cited at F-600 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was removed onsite and was effective from 10/2/2019 through [DATE]. An Immediate Action Removal Plan, which removed the immediacy of the jeopardy was received on [DATE] at 2:55 PM. The corrective actions were validated onsite by the surveyors on [DATE]. The facility's noncompliance at F-600 continues a a scope and severity of, D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: Review of the facility policy, Abuse Prohibition Plan, revised 5/2019, revealed, .The facility has a zero-tolerance policy for abuse. Verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion is prohibited. The resident will not be subjected to mistreatment, neglect, exploitation or misappropriation of property. The facility will attempt to identify and will investigate any reported violation or allegation of abuse.Willful means the individual deliberately, not that the individual must have intended to, inflict injury or harm. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #33 was cognitively intact. Further review revealed the resident required 2 person total assist with transfers. Review of the Comprehensive Care Plan dated 9/25/2019, showed, .Transfers-(Mechanical) Lift Assist. Review of Resident #33's Physician Visit note dated 10/23/2019 showed Resident #33 was having left shoulder pain and an X-ray was ordered. Review of Resident #33's Mobile Radiology report dated 10/23/2019, showed, .Impacted nondisplaced left humeral fracture.NP (Nurse Practitioner) made aware. Review of Resident #33's Physician Order Sheet dated September 13, 2019 showed, .[MEDICATION NAME] 25mcg (micrograms)/hr (hour) [MEDICATION NAME] 1 patch [MEDICATION NAME] every 72 hrs for pain.9/18/2019 [MEDICATION NAME] 10 mg (milligram) every 6 hrs for pain. Review of Resident #33's physician order dated 10/23/2020 showed, .Biofreeze (topical pain medication)4% topical gel to left shoulder prn (as needed) for pain. Review of Resident #33's Physician Visit note dated 10/25/2019, showed Resident #33 had a contusion to her left arm and the X-ray showed fracture. Further review showed, .Send to Ortho (Orthopedic) Urgent Care for further evaluation of L (Left) Shoulder pain to eval (evaluation) and fx(fracture)/treatment. Review of Resident #33's Orthopedic Consult Note (from the Orthopedic Urgent Care Center) dated 10/25/2020 showed, .10/22/2019 someone was attempting to transfer her and squeezed her too tightly. An xray performed at the facility reported a fracture. She has pain from her left shoulder radiating down into the left forearm. The pain has been worsening and is exacerbated by lifting, moving and exertion. There is associated bruising as well. Plan: Sling, Send to ER (emergency room ), discussed that the xrays to reveal evidence of a fracture at the humerus. Review of Resident #33's ER Note dated 10/25/2019 showed, .a tech was transferring her from her wheelchair to a bed 2 days ago. He tried to lift her under her arms. When this occurred she felt a pop in her left shoulder. She has had pain ever since then. It is sharp and throbbing, 10 out of 10 in severity, it is worse with movement. She has noticed some increased bruising, she denies any other injuries. Review of Resident #33's ER Radiology report of the left humerus dated 10/25/2019, showed, .Comminuted fractures proximal humerus. Review of Resident #33's Clinical Notes Report dated 10/25/2019, showed, .Resident returned from ER by ambulance/stretcher. Awake alert and oriented. Diagnosis: [REDACTED]. Sling to left arm in place. Review of Resident #33's Psychotherapy notes dated 10/28/2019, 11/4/2019, 11/18/2019, and 12/2/2019, showed she was receiving psychotherapy related to her increased anxieties, frustration, and concern over the incident that occurred 10/22/2019. Review of Resident #33's Physician Orders dated 1[DATE]19, showed a new medication order as follows: .[MEDICATION NAME] (medication for anxiety) 1 milligram (mg) 1 PO (by mouth) BID (twice daily) PRN (as needed) in adjunction to (in addition to) scheduled dose. Continued review indicated she received 16 doses of the PRN [MEDICATION NAME] from 1[DATE]19 through 12/4/2019 following the incident. Review of the facility's documentation titled, Activity Calendar, dated October 2019, showed, Bingo scheduled on 10/22/2019 at 3:00 PM. During an interview on [DATE] at 9:05 AM, Resident #33 stated about 4 months ago I was lying in bed when (named CNA #1) came in and was going to get me up for bingo. He didn't have a lift and I told him 'No!' I'm not going without the lift. I asked him to please get the lift, but he wouldn't go get it. During further interview revealed CNA #1 proceeded to lift the resident by her arms to transfer her to a chair from the bed. Resident #33 stated, When he pulled me up, I heard a loud pop and I started having pain in my left arm. I told him it hurt, but he just said, 'You didn't break your arm!' Then he picked up my arm and moved it around and |

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

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| F 0600<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>said, 'see'.It really hurt when he did that. During further interview revealed Resident #33 informed the Director of Nursing (DON) the next day that CNA #1 did not use the lift when he attempted to transfer her and she insisted for him to use the lift, but he didn't and when he pulled her up by her arms she heard a pop and began to have pain in her left arm. Review of the medical record showed Resident #13 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Significant Change MDS dated [DATE], showed, Resident #13 was cognitively intact. During an interview on [DATE] at 3:30 PM with Resident #13, Resident #33's roommate, she stated she had been Resident #33's roommate since 9/2019. Further interview she stated she was lying in her bed when CNA #1 attempted to transfer Resident #33. She stated, I heard (named Resident #33) tell (named CNA #1) 'No, No' but (named CNA #1) continued to get (named Resident #33) up. During further interview she stated they usually use a mechanical lift to get Resident #33 out of bed, but CNA #1 did not have one and additional staff assistance. During a telephone Interview on [DATE] at 1:13 PM, Resident #33's family member stated Resident #33 told her CNA #1 attempted to get her up for Bingo without assistance. Further interview she stated he didn't use the lift and she thought her arm was broke during the attempted transfer. During further interview revealed Resident #33 told her CNA #1 took her arm and moved it up and down after she told him she heard a pop and she stated she had pain in her left arm. Further interview she stated, (named Resident #33) cries every time she talks about the situation with her arm. During an interview on [DATE] at 2:00 PM with the Activities Director confirmed Resident #33 would attend Bingo 2 days a week, on Tuesday and Thursday, but did not attend on Tuesday, 10/22/2019. During an interview on [DATE] at 4:19 PM with Nurse Practitioner #1 she stated the facility told her this injury was chronic. However on her 10/25/2019's assessment she found fresh bruising and contusions on her left arm. During further interview she stated when she talked to Resident #33's family member, she said Resident #33 had a fracture to her neck a couple of years ago, not her arm. That's when I ordered for (named Resident #33) to be sent to Orthopedic Urgent care for further evaluation of left shoulder pain and fracture. During an interview on [DATE] at 4:30 PM with Licensed Practical Nurse #2 stated Resident #33 reported to her that her arm was hurting after CNA #1 had lifted her. During further interview revealed Resident #33 reported CNA #1 bear hugged her and she felt pain in her arm and the pain did not go away. During further interview she stated, I re-educated (named CNA #1) to use 2 person assist and mechanical lift with (named Resident #33). During further interview she stated she reported the incident to her supervisor and was informed they already knew about it. During an interview on [DATE] at 4:51 PM with the Director of Nursing (DON) confirmed Resident #33 was a 2 person assist transfer with a mechanical lift, since admission. Further interview she stated Resident #33 felt CNA #1 was a little rough during the transfer when her arm was broken. During further interview she stated, If a resident reported a CNA was rough, I would report it to the administrator, go to the CNA, consider the resident's ability as a historian, would take all factors into consideration and investigate it to rule it out as abuse. During further interview the DON confirmed she was notified by Resident #33 on 10/25/2019 that CNA #1 was rough with her during the attempted transfer on 10/22/2019. During an interview on [DATE] at 5:16 PM with the Administrator confirmed the incident involving Resident #33 was reported to her by the DON in October 2019 but was not considered abuse at that time. During an interview on [DATE] at 12:25 PM Resident #33 became tearful and began to cry, when she recalled the incident involving CNA #1 in October (2019), and she continued to cry through the remainder of the interview. During an interview on [DATE] at 4:45 PM with Resident #33 in her room she stated, Every time I see (named CNA #1), I cry because there were a lot of things I could do before this happened and now I can't do them, now I have to ask for help to even pull myself up in bed. Resident #33 began to cry again and stated, I am afraid of (named CNA #1). During a telephone interview on [DATE] at 4:00 PM with the Psychologist, he confirmed, I see (named Resident #33) once a week for anxiety and the injury had caused her pain and discomfort. Further interview he stated Resident #33 was frustrated and anxious about her arm and focused on the incident with her arm every week for 4 weeks right after the incident happened. An Immediate Action Removal Plan, which removed the immediacy of the Jeopardy, was received on [DATE] at 2:55 PM and corrective actions were validated on site by the surveyors on [DATE]. The Immediate Action Removal Plan was verified by the surveyors on [DATE] by: 1. The surveyors verified through review of CNA #1's employee file, CNA #1 was placed on suspension pending completion of investigation on [DATE] and the facility substantiated the allegation of abuse. 2. The surveyors verified the facility's policy to report and investigate any events through review of staff education. Staff interviews on abuse allegation reporting and interview with the Administrator of events that occurred. Review of events reported on [DATE]. 3. The surveyors verified the facility's Incident Reporting System intake information regarding Resident #33 and CNA #1 was reported to the state agency on [DATE]. 4. The surveyors verified Resident #33 was seen on [DATE] by the Psychiatric Nurse Practitioner through review of the Psychiatric Nurse Practitioner consult notes dated [DATE] and by interview on [DATE]. 5. The surveyors verified the facility interviewed Resident #33 and her family member obtaining statements. 6. The surveyors verified an abuse investigation was conducted on [DATE]. The surveyors verified interviews with interviewable residents and skin assessments were conducted on non interviewable residents. 7. The surveyors reviewed the facility's abuse policy and verified there were no changes made to the policy. 8. The surveyors verified staff education of abuse to include the definition and examples of willful abuse. The facility's noncompliance at F-600 continues at a scope and severity of D for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |
| F 0609<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility policy review, medical record review, and interview the facility failed to report an abuse allegation to the State Survey Agency for 1 of 38 residents (Resident #33) reviewed or abuse. The Administrator, Director of Nursing (DON), and Regional Nurse Consultants were notified of the Immediate Jeopardy (IJ) on [DATE] at 7:31 PM in the Administrator's office. The facility was cited Immediate Jeopardy at F-609. The facility was cited at F-609 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was removed onsite and was effective from 10/2/2019 through [DATE]. An Immediate Action Removal Plan, which removed the immediacy of the jeopardy was received on [DATE] at 2:55 PM. The corrective actions were validated onsite by the surveyors on [DATE]. The facility's noncompliance at F-609 continues a a scope and severity of, D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: Review of the facility policy titled, Abuse Prohibition Plan, revised 5/2019, showed, .It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Regulations and Law.All alleged violations are reported immediately but not later than 2 hours after the allegation is made, if the events that caused the allegations involve or result in serious bodily injury. Review of the medical record showed Resident #33 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], showed the resident was cognitively intact. Further review revealed the resident required 2 person total assist transfers. Review of the Comprehensive Care plan dated 9/25/2019, showed, .Transfers-(mechanical) lift assist. Review of the Radiology report dated 10/23/2019, showed, .Impacted nondisplaced left humeral fracture. During an interview on [DATE] at 9:05 AM, Resident #33 stated about 4 months ago I was lying in bed when (named CNA #1) came in and was going to get me up for bingo. He didn't have a lift and I told him 'No!' I'm not going without the lift. I asked him to please get the lift, but he wouldn't go get it. During further interview she stated CNA #1 proceeded to lift the resident by her arms to transfer her to a chair from the bed. Resident #33 stated, When he pulled me up, I heard a loud pop and I started having pain in my left arm. I told him it hurt, but he just said, 'You didn't break your arm!' Then he picked up my arm and moved it around and said, 'see'.It really hurt when he did that. During further interview she stated she informed the Director of Nursing (DON) the next day that CNA #1 did not use the lift when he attempted to transfer her and she insisted for him to use the lift, but he didn't and when he pulled her up by her arms she heard a pop and began to have pain in her left arm. During a telephone Interview on [DATE] at 1:13 PM, Resident #33's family member stated Resident #33 told her CNA #1 attempted to get her up for Bingo without assistance. During further interview she stated he didn't use the lift and she thought her arm was broke during the attempted transfer. During further interview she stated Resident #33 told her CNA #1 took her arm and moved it up and down after she told him she heard a pop and she stated she had pain in her left arm. During further interview she stated, (named Resident #33) cries every time she |

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| F 0609<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 2)<br>talks about the situation with her arm. During an interview on [DATE] at 4:51 PM with the Director of Nursing (DON) she stated she had 24 hours to report an abuse allegation to the state survey agency after she investigated and determined it was qualified as abuse. Further interview she stated, I don't know what the policy is. During an interview on [DATE] at 5:16 PM with the Administrator she stated the incident involving Resident #33 and CNA #1 on 10/22/2019 was not reported to the state survey agency. An Immediate Action Removal Plan, which removed the immediacy of the Jeopardy, was received on [DATE] at 2:55 PM and corrective actions were validated on site by the surveyors on [DATE]. The Immediate Action Removal Plan was verified by the surveyors on [DATE] by: 1. The surveyors verified the facility's policy to report and investigate any events through review of staff education. Staff interviews on abuse allegation reporting and interview with the Administrator of events that occurred. Review of events reported on [DATE]. 2. The surveyors verified the facility's Incident Reporting System intake information regarding Resident #33 and CNA #1 was reported to the state agency on [DATE]. 3. The surveyors reviewed the facility's abuse policy and verified there were no changes made to the policy. The facility's noncompliance at F-609 continues at a scope and severity of D for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |
| F 0610<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Respond appropriately to all alleged violations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility policy review, medical record review, and interview, the facility failed to investigate an abuse allegation for 1 of 38 residents (Resident #33) reviewed for abuse. The facility was cited Immediate Jeopardy at F-610. The facility was cited at F-610 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was removed onsite and was effective from 10/2/2019 through [DATE]. An Immediate Action Removal Plan, which removed the immediacy of the jeopardy was received on [DATE] at 2:55 PM. The corrective actions were validated onsite by the surveyors on [DATE]. The facility's noncompliance at F-610 continues a a scope and severity of, D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: Review of the facility policy, Abuse Prohibition Plan, revised 5/2019, showed, .The policy of this facility is that reports of abuse, neglect, exploitation, misappropriation of resident's property and injuries of unknown origin are promptly and thoroughly investigated. The Administrator will investigate or assign the investigation to designated facility personnel such as the Director of Nursing (DON). The investigation will begin immediately. Review of the medical record showed Resident #33 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment<br>dated [DATE] showed Resident #33 was cognitively intact. Further review revealed the resident required 2 person total assist with transfers. Review of the Radiology report dated 10/23/2019, showed, .Impacted nondisplaced left humeral (long bone that extends from the elbow to the shoulder) fracture. During an interview on [DATE] at 9:05 AM, Resident #33 stated about 4 months ago I was lying in bed when (named CNA #1) came in and was going to get me up for bingo. He didn't have a lift and I told him 'No!' I'm not going without the lift. I asked him to please get the lift, but he wouldn't go get it. Further interview revealed CNA #1 proceeded to lift the resident by her arms to transfer her to a chair from the bed. Resident #33 stated, When he pulled me up, I heard a loud pop and I started having pain in my left arm. I told him it hurt, but he just said, 'You didn't break your arm!' Then he picked up my arm and moved it around and said, 'see'.It really hurt when he did that. Further interview revealed Resident #33 informed the Director of Nursing (DON) the next day that CNA #1 did not use the lift when he attempted to transfer her and she insisted for him to use the lift, but he didn't and when he pulled her up by her arms she heard a pop and began to have pain in her left arm. During a telephone Interview on [DATE] at 1:13 PM, Resident #33's family member stated Resident #33 told her CNA #1 attempted to get her up for Bingo without assistance. Further interview she stated he didn't use the lift and she thought her arm was broke during the attempted transfer. Further interview revealed Resident #33 told her CNA #1 took her arm and moved it up and down after she told him she heard a pop and she stated she had pain in her left arm. Further interview she stated, (named Resident #33) cries every time she talks about the situation with her arm. During an interview on [DATE] at 4:51 PM with the Director of Nursing (DON) she stated an investigation involving Resident #33 on 10/22/2019 was not done. During an interview on [DATE] at 5:16 PM with the Administrator confirmed the incident on 10/22/2019 involving Resident #33 was not investigated. An Immediate Action Removal Plan, which removed the immediacy of the Jeopardy, was received on [DATE] at 2:55 PM and corrective actions were validated on site by the surveyors on [DATE]. The Immediate Action Removal Plan was verified by the surveyors on [DATE] by: The surveyors verified an abuse investigation was conducted on [DATE]. The surveyors verified interviews with interviewable residents and skin assessments were conducted on non interviewable residents. 1. The surveyors reviewed the facility's abuse policy and verified there were no changes made to the policy. 2. The surveyors verified through review of facility documentation dated [DATE], [DATE], and [DATE] QAPI meetings were held regarding Residents #33. 3. The surveyors verified through review education was provided to staff concerning the Abuse Prohibition Plan/Policy. The facility's noncompliance at F-610 continues at a scope and severity of D for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |
| F 0656<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility policy review, medical record review and interview, the facility failed to develop and implement a person centered care plan with interventions related to blood sugar monitoring and tube feeding residual to prevent [DIAGNOSES REDACTED] for 1 of 38 residents (Resident #77) reviewed for implementation of care plans placing Resident #77 in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) when Resident #77 became unresponsive, hypoglycemic, and required emergent hospitalization . The Administrator and the Director of Nursing (DON) were informed of the Immediate Jeopardy (IJ) on 3/5/2020 at 3:50 PM in the Administrators office. The facility was cited Immediate Jeopardy at F-656. The facility was cited F-656 at a scope and severity Level of J. The Immediate Jeopardy was effective from 10/2/2019 through 3/5/2020. The Immediate Jeopardy was removed onsite and was effective 10/2/2019 through 3/5/2020. An Immediate Action Removal Plan, which removed the immediacy of the jeopardy, was received on 3/6/2020 at 2:55 PM. The corrective actions were validated onsite by the surveyors on 3/6/2020. The findings include: Review of the facility policy, Comprehensive Care Plan, revised 12/2019, showed .The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team or in accordance with the resident's preferences and potential for discharge, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record . Review of the medical record showed Resident #77 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] showed Resident #77 was severely cognitively impaired. Continued review revealed Resident #77 required tube feeding for nutrition. Review of the hospital History of Present Illness dated 1/23/2020, showed .Today, the patient was altered and less interactive, and EMS (Emergency Medical Services) was called. EMS said they got a blood glucose of 12 at his home. He was brought to the emergency room where D5 was started and the patient's mental status recovered quickly to baseline .the patient's core temperature was also found to be 91 degrees . Review of the Comprehensive Care Plan dated [DATE] showed Resident #77 had no care plan for [DIAGNOSES REDACTED] or for monitoring for<br>signs and symptoms of [DIAGNOSES REDACTED]; length of time to hold tube feeding when residual was too high; and appropriate physician notification. Further review showed no new interventions were placed for monitoring signs and symptoms of [DIAGNOSES REDACTED] for Resident #77 after his return to the facility after his hospitalization on [DATE]. Review of the Nursing Notes dated 2/3/2020, showed, Resident #77 was receiving [MEDICATION NAME] 1.5 at 40 ml/hr (milliliters per hour). Review of the progress note dated 2/23/2020, showed, approximately 1435 (2:35 PM) resident became non responsive after having a second BM (bowel movement). Resident had been disconnected from tube feeding after checking residual and having > (greater than) 110 ml residual (replaced) x's 2. NP (Nurse Practitioner) notified and gave orders to send resident out for evaluation and treatment. Medical record review of the vital signs dated for 2/23/2020, revealed no documented blood sugar prior to transfer to the hospital by the facility. Review of the Emergency Patient Record dated 2/23/2020, showed .Per EMS (Emergency Medical Service) The initial call was for an unresponsive PT (patient). Nurses at this facility saw that he went unresponsive 40 minutes. Our glucometer read L0 for us. We gave him D10 ([MEDICATION NAME] 10%) infusion. |

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| F 0656<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 3)<br>He's had a low heart rate with 'us' and weak carotid pulses .Intraosseous special catheter (surgical steel IV (intravenous) catheter inserted directly into a patient's long bone in an emergency life threatening situation to provide rapid infusion of life saving medications/solutions) left tibia inserted at 1536 (3:36 PM) . Review of (Named Hospital) History of Present Illness dated [DATE]20, showed, .TF had reportedly been temporarily stopped D/T (due to) high gastric residuals/apparent constipation. Ultimately staff found resident unresponsive and checked BS (blood sugar) which read low. He was also hypothermic -T-max 89 F (maximum temperature 89 degrees Fahrenheit). Had significant BM today however TF was never resumed . Review of Emergency Provider Report dated [DATE]20 showed, .1. [DIAGNOSES REDACTED] 2. Hypothermia 3.<br>Severe Protein-Calorie Malnutrition .Apparent difficulty tolerating TF which was ultimately held .Received multiple amps (unit dose vials) of D50 ([MEDICATION NAME] 50 % (used in an emergency to treat [DIAGNOSES REDACTED])) and started D5 drip<br>([MEDICATION NAME] 5 % (IV infusion to sustain normal blood glucose level)) .Emergency warming blanket .Patient critically ill due to Hypothermia/[DIAGNOSES REDACTED] . Review of Resident #77's Patient Medication Profile dated 2/29/2020, revealed, .[MEDICATION NAME] emergency kit 1 mg as needed for [DIAGNOSES REDACTED] . During an interview on 3/5/2020 at<br>11:12 AM with Licensed Practical Nurse (LPN) #4, confirmed Resident #77 had a residual of 200 mL at 12:00 PM on 2/23/2020 and she did not call the medical doctor or nurse practitioner to report the high residual. Continued interview LPN #4 stated when Resident #77 became unresponsive she did not think to check his blood sugar. During an interview on 3/5/2020 at 3:50 PM with the Director of Nursing (DON) she confirmed Resident #77 had a history of [REDACTED]. glucose level should have been monitored. During a telephone interview with the Medical Director on 3/5/2020 at 5:19 PM, confirmed the paramedics checked Resident #77's blood sugar when they arrived on 2/23/2020. He stated, They checked it for us. During continued interview he confirmed the blood sugar dropped from the resident not receiving his tube feeding. An Immediate Action Removal Plan, which removed the Immediacy of the Jeopardy, was received on 3/6/2020 at 3:50 PM and corrective actions were validated on site by the surveyor on 3/6/2020. The surveyors verified the Removal Plan by: 1). Verified the care plans with interventions were in place for 17 residents at risk for developing low blood sugar. 2). Reviewed and validated staff education on recognizing signs and symptoms of low blood sugar. 3). Interviewed staff for returned knowledge of signs and symptoms of low blood sugar. The facility's noncompliance at F-656 continues at a scope and severity level of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |
| F 0678<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | **Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>Based on facility policy review, medical record review, and interview the facility failed to ensure a resident's Advance Directive preference was accurately reflected in the medical record for 2 of 91 residents (Resident #49 and #6) reviewed for Advance Directives, placing the residents in an Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The facility's failure to follow their procedures for processing Advance Directives, had the potential for staff not intervening with life saving measures, (CPR (Cardiopulmonary Resuscitation)) for Resident #49 when Resident #49 wanted CPR and intervening with life saving measures (CPR) for Resident #6, when Resident #6 wanted to be a DNR (Do Not Resuscitate). The Administrator, Director of Nursing (DON), and Regional Nurse Consultants were notified of the Immediate jeopardy on [DATE] at 9:20 PM in the Administrator's office. The facility was cited Immediate Jeopardy at F-678. The facility was cited at F-678 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was removed onsite and was effective from [DATE] through [DATE]. An Immediate Action Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE] at 2:55 PM. The corrective actions were validated onsite by the surveyors on [DATE]. The facility's noncompliance at F-678 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include:<br>Review of the facility policy, Advance Directives, revised on ,[DATE], showed, .The facility representative will assist the resident as needed to communicate any changes in the resident's Advance Directive to the physician and/or responsible party .The facility representative will discuss and provide written information explaining the Advance Directive Program, upon admission to the facility .The facility representative will periodically discuss the resident's Advance Directive to ensure the resident's wishes concerning end of life treatment have not changed . Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #49 was cognitively intact. Review of the Physician Orders for Scope of Treatment (POST) for Resident #49 dated [DATE] located in the POST Form Book at the Nurses station showed the resident's code status was a DNR (Do not resuscitate). Review of Resident #49's EMR (Electronic Medical Record) showed the Code Status Ribbon (which displayed for quick reference at the top of the resident's EMR) was blank, which indicated the resident's code status was Full Code (Cardiopulmonary Resuscitation (CPR)). Review of Resident #49's Comprehensive Care Plan dated [DATE], showed a Code Status of Full Code. Review of Resident #49's Face Sheet, the Advance Directives section showed the directive was listed as Full Code. During an interview on [DATE] at 6:44 PM, with Licensed Practical Nurse (LPN) #6, who was assigned to Resident #49, she stated she would refer to the POST Form Book located at the nurses' station to determine a resident's code status. During an interview on [DATE] at 6:45 PM, LPN #7 stated she would refer the POST Form Book located at the nurses' station to determine for a resident's code status. During an interview on [DATE] at 7:40 PM, Resident #49 stated he wanted CPR if his heart stopped and his decision had not changed since admission to the facility. Review of the medical record showed Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's Admission MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident #6's POST dated [DATE] located in the Post Form book showed the resident code status was Full Code. Review of Resident #6's EMR showed the Code Status Ribbon displayed an Advance Directive status of Do Not Resuscitate (DNR). Review of Resident #6's Face Sheet, the Advance Directives section for showed the directive was listed as Do Not Resuscitate. Review of Resident #6's Care Plan dated [DATE] showed Resident #6's code status was DNR. During an interview on [DATE] at 5:43 PM with LPN #1, who was assigned to Resident #6, she stated she would look on the computer for a resident's code status. Further interview she stated, The code status is in bold right next to the resident's name on the computer. She then demonstrated this on the computer screen by opening the resident's EMR and pointing to the ribbon at the top of the screen where DNR was highlighted in yellow. During an interview on [DATE] at 6:27 PM with the Administrator confirmed code status on the POST forms for Resident #49 and Resident #6 conflicted with their code statuses in the EMR. During an interview with Registered Nurse (RN) #1 on [DATE] at 6:40 PM, who was assigned to Resident #6, he stated, If a resident coded (if the resident had no pulse and was not breathing) I would go to the computer and check the resident's code status. Further interview RN #1 stated, I can tell if a resident has a Full Code or DNR status by looking at the Code Status ribbon at the top of their EMR, it is in bold letters on the face sheet. Further interview RN #1 demonstrated obtaining Resident #6's code status by opening his computer and pointing to the ribbon at the top of the screen of Resident #6's EMR where DNR was highlighted in yellow. During an interview on [DATE] at 7:10 PM, with Admissions Clerk stated she was responsible to get the POST form signed by the resident and the doctor. Further interview revealed once the POST form was signed by the resident and the doctor, she would enter the code status selection in the computer. Further interview she stated if the resident was a full code the ribbon was blank and if the resident was a DNR it would display in yellow on the ribbon in the Resident's EMR. Further interview she stated she placed the original POST form in the POST form book at the nurses station. During an interview on [DATE] at 8:19 PM, the Administrator confirmed staff were not to rely on the computer, but refer to the POST Form book located at the nurses' station for a resident's code status. Further interview confirmed the staff had not been educated on referring to the POST Form book, not the computer, for a resident's code status. During an interview on [DATE] at 10:00 AM, the Administrator stated Admissions personnel were responsible for getting a POST form signed by the resident and the doctor, putting the code status in the Resident's EMR, and putting the POST form in the book at the nurses' station. Further interview she stated the MDS nurse was to go to the POST book at the nurses' station to get a resident's code status for implementation of an Advance Directive care plan. Further interview confirmed this process did not happen for Residents #49 and #6. During an interview on [DATE] at 11:52 AM, MDS Coordinator confirmed she looked in the computer for |

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|---|---|---|---|
| | 445439 | A. BUILDING _____ B. WING _____ | 03/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| MT JULIET HEALTH CARE CENTER | 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0678<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | (continued... from page 4)<br>the POST form she did not refer to the book at the nurses' station when implementing a resident's Advance Directive Care Plan. Further interview confirmed the code statuses on the POST forms for Resident #49 and #6 conflicted with the code status on their care plans. She stated, There was a process failure. An Immediate Action Removal Plan which removed the immediacy of the Jeopardy was received on [DATE] at 2:55 PM and corrective actions were validated on site by the surveyors on [DATE]. The Immediate Action Removal Plan was verified by the surveyors on [DATE] by: 1. The surveyors verified through review of Resident #49 and #6's POST forms were accurately reflected in the electronic medical record. 2. The surveyors verified through review of all facility residents' POST forms and the EMR to ensure accuracy. No other resident was found to have a POST that was inaccurately reflected on the EMR. 3. The surveyors verified through review of the education completed on [DATE] to all on duty and off duty licensed nurses and certified nursing assistants regarding verifying a code status through the Disaster Readiness/POST form book located at the nurses' station. 4. The surveyors verified through review of the education completed on [DATE] and interviews with Social Services, Admissions, and Nursing Management regarding the process of updating a POST form and ensuring it was reflected in the electronic medical record. 5. The surveyors verified through review of the education completed on [DATE] and interviews with the Administrator and the Director of Nursing regarding the new process for auditing the POST form through the Code Status audit tool on new admissions/readmission and residents with annual, quarterly, or significant change assessments and to ensure their advanced directive preferences were accurate and reflected in the electronic medical record. Once the POST form is completed it is communicated with the staff and placed in the Disaster Readiness/POST form book located at the nurses' station. 6. The surveyors verified through review of the education completed on [DATE] to on duty and off duty licensed nurses and certified nursing assistants regarding verifying a code status no longer be entered in the ribbon or in the resident care needs (Customized Approach to Care for an individual resident's needs for Certified Nursing Assistants) and to utilize the signed POST form in the Disaster Readiness/POST form book located at the nurses' station to advise of residents' advanced directive preferences. Alerts placed at the nurses' station as a reminder to no longer reference the ribbon and/or resident care needs. 7. The surveyors verified through interviews with various licensed nurses and certified nursing assistants regarding verifying a resident's code status and the location of the Disaster Readiness/POST form book. The facility's noncompliance at F-678 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |
| F 0693<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | **Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review, observation, and interview the facility failed to ensure the prescribed tube feeding formula was available for 1 of 5 residents (Resident #77) reviewed for tube feedings when Resident #77's prescribed tube feeding was substituted with a tube feeding formula that required an increase in rate to equal the nutritional value. The increase in the tube feeding rate resulted in Resident #77's increased residuals, tube feedings held frequently, and rate had to be decreased, so the resident was not provided the required caloric intake to sustain him in his severely malnourished state, which resulted in unresponsiveness, [DIAGNOSES REDACTED], and emergent hospitalization . The Administrator, Director of Nursing (DON), and Regional Nurse Consultants were notified of the Immediate Jeopardy (IJ) on [DATE] at 7:31 PM in the Administrator's office. The facility was cited Immediate Jeopardy at F-693. The facility was cited at F-693 at a scope and severity of J, which is Substandard Quality of Care. The Immediate Jeopardy was removed onsite and was effective from 10/2/2019 through [DATE]. An Immediate Action Removal Plan, which removed the immediacy of the jeopardy was received on [DATE] at 2:55 PM. The corrective actions were validated onsite by the surveyors on [DATE]. The facility's noncompliance at F-693 continues a a scope and severity of, D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: Medical record review revealed Resident #77 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #77 was severely cognitively impaired. Continued review revealed Resident #77 required tube feeding for nutrition. Medical record review of the Care Plan dated [DATE] revealed Resident #77 was at risk for compromised nutritional status related to tube feeding. Interventions included to calculate caloric needs/fluid requirements and adjust based on weight, tolerance, and hydration status. Continued interventions included check tube placement by aspiration before giving feeding/meds; elevate head of bed; monitor and document weight; and report diarrhea, decreased urine output, and dry mucous membranes to dietitian. Review of Physician's admission orders [REDACTED]. Review of the Progress Notes dated [DATE], showed, .Unit Manager advised, currently out of [MEDICATION NAME] 1.5, using [MEDICATION NAME] 1.2. Unit Manager working with supply company to get [MEDICATION NAME] 1.5 as soon as possible. Review of a Dietary Note dated [DATE], showed, .Unit Manager advised currently out of [MEDICATION NAME] 1.5, using [MEDICATION NAME]<br>1.2. Unit Manager working with supply company to get [MEDICATION NAME] 1.5 as soon as possible. Currently running [MEDICATION NAME] 1.2 @ 40 ml/hr x 24 hours with 30 ml water autoflush and 30 ml water flush before and after meds BID (twice daily) providing 1152 calories. Recommend increasing rate to 45 ml/hr x 24 hours. Increased rate along with flushes will provide 1286 calories. Once [MEDICATION NAME] 1.5 available recommend going back to previous TF orders. Review of the Physician order [REDACTED].Until [MEDICATION NAME] 1.5 available, run [MEDICATION NAME] 1.2 @ (at) 45 mL (milliliter) / hr<br>(hour) x 24 hours w /(with) 30 mL H20 (water) autoflush. Once [MEDICATION NAME] 1.5 available, return to previous TF (tube feeding) order of [MEDICATION NAME] 1.5 @ 40 mL /hr x 24 w/ 30 mL H20 autoflush. Review of the medical record showed Resident #77 had significant amounts of residual with his feedings. The rate ordered was 40 ml/hr, but the rate was decreased as low as 25 ml/hr to compensate for the large residuals. The resident, with a history of malnutrition, failed to receive the necessary calories to sustain him and prevent low blood sugar as evidenced by [DIAGNOSES REDACTED], unresponsiveness, and emergent hospitalization on [DATE]. Medical record review of the Treatment Record dated [DATE] revealed .[MEDICATION NAME] 1.5 @ (at) 40 mL (milliliter) / HR (hour) x 20 hours (off from 1 PM-5 PM) with 30 mL H20 (water) autoflush. Medical record review of Nursing Notes dated [DATE] at 10:36 PM revealed .earlier today, approximately 1 pm (1:00 PM) resident's mother informed this nurse that the resident was having a birthday party around 3 pm (3:00 PM) and would like to turn his enteral feeding off around 3 pm instead of 1 pm. approximately 245 pm (2:45 PM) resident was disconnected from feeding, reported to oncoming nurse that feeding should be reconnected at approximately 7 pm (7:00 PM) instead of 5 pm (5:00 PM). Observation on [DATE] at 7:36 PM and 8:16 PM revealed Resident #77 was not receiving the tube feeding. Review of the medical record revealed no documentation the physician was notified for a one-time order to change the times the tube feeding was off. Interview with Licensed Practical Nurse (LPN) #6 on [DATE] at 8:16 PM, revealed Resident #77's tube feeding had not been restarted since the beginning of the shift. Continued interview revealed Resident #77 did not receive tube feeding from 1:00 PM to 5:00 PM as ordered and LPN #6 stated she did not know why the tube feeding was not restarted at 5:00 PM as scheduled. Continued interview revealed LPN #6 stated she did not receive report from the previous nurse who cared for Resident #77. Interview with the Assistant Director of Nursing on [DATE] at 8:25 PM, confirmed she was the nurse from 8:00 AM to 3:00 PM and another nurse took over care on that hall. Continued interview confirmed Resident #77's tube feeding was turned off at approximately 2:30 PM instead of 1:00 PM as ordered. During an interview with the Registered Dietician (RD) on [DATE] at 10:19 AM, confirmed she was not notified until [DATE] when the Unit Manger contacted her to inform her the facility supply of [MEDICATION NAME] 1.5 was depleted. During further interview confirmed she expected the formula to be overnighted to the facility at the latest, however Resident #77 was still receiving [MEDICATION NAME] 1.2 the day he was found unresponsive and was transferred to the hospital via ambulance. The Immediate Action Removal Plan was verified by the surveyors on [DATE] by: 1. The surveyors verified through record review, observations and interviews Resident #77 received the correct tube feeding at the correct rate. 2. The surveyors verified through review of facility documentation dated [DATE], [DATE], and [DATE] QAPI meetings were held regarding corrective action plans for Resident #77 to include auditing for correct feeding and rates as prescribed . 3. The surveyors verified through record review education provided to licensed nurses regarding administering enteral tube feedings per Physician orders. The facility's noncompliance at F-693 continues at a scope and severity of D for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |
| F 0694<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide for the safe, appropriate administration of IV fluids for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on medical record review, observation and interview, the facility failed to change, date, and initial a PICC |

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|---|---|---|---|
| | 445439 | A. BUILDING _____ B. WING _____ | 03/10/2020 |

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0694<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 5)<br>(peripherally inserted central catheter) (a form of intravenous access that can be used for prolonged period of time) line dressing for 3 (Resident #58, #68, and #135) of 5 residents reviewed with PICC lines. The findings include: Medical record review revealed Resident #58 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. Continued review indicated Resident #58 required IV (intravenous) medications. Medical record review of the Care Plan dated [DATE] revealed .Monitor IV site for redness and swelling. Observe for infiltration, coolness, hard to touch . Continued review revealed no interventions related to changing the dressing. Medical record review of the Physician order [REDACTED].[MEDICATION NAME] (antibiotic) 2 g (gram) IV piggyback<br>BID (twice daily) x 13 days .[MEDICATION NAME] lock flush ([MEDICATION NAME]) 100 unit/mL (milliliter) intravenous solution 5 mL Q12hrs (every 12 hours) . Continued review of the orders dated 1/18/2020 revealed .Change PICC transparent dressing every 7 days . Observation on [DATE] at 10:14 AM revealed Resident #58's PICC line dressing was undated. Observation on 3/ 3/2020 at 11:27 AM and again at 12:34 PM revealed Resident #58's PICC line dressing was undated. Medical record review revealed Resident #68 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the 5 day MDS dated [DATE] revealed Resident #68 had a BIMS score of 15 indicating no cognitive impairment. Continued review indicated Resident #68 required IV medications. Medical record review of the Physician order [REDACTED].[MEDICATION NAME]<br>tazobactam (antibiotic) 3.375 grm (grams) Intravenous solution q8hrs (every 8 hours) for 42 days .Dressing Change Every 7 days . Medical record review of the Care Plan dated [DATE] .At risk for complications related to IV ABT (antibiotic) .Picks at his PICC line risk for infection and dislodging IV . Observation on 3/3/2020 at 2:12 PM revealed Resident #68's PICC line dressing had a date of [DATE]20. Medical record review revealed Resident #135 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Medical record review of the 5 day MDS dated [DATE] revealed Resident #135 had a BIMS<br>score of 15 indicating no cognitive impairment. Continued review revealed Resident #135 required IV medications. Medical record review of the Care Plan dated [DATE] revealed .at risk for complications related to (named Resident #135) receiving IV ABT . Medical record review of the Physician order [REDACTED].[MEDICATION NAME] (antibiotic) 1,000 mg (milligram) Intravenous injection (one) vial BID . Continued review of orders revealed an order for [REDACTED].#135's PICC line dressing was undated. There was no documentation as to when the line was placed or when the dressing was last changed. Observation on 3/3/2020 at 12:37 PM revealed Resident #135's PICC line dressing was undated. During an interview on [DATE] at 10:51 AM with Licensed Practical Nurse (LPN) #4, she stated the Registered Nurses (RN) change the PICC line dressings and the LPNs chart the dressing changes. Continued interview confirmed the RNs would document their initials and date on the PICC line dressings. During an interview on 3/3/2020 at 11:30 AM with RN #2, she confirmed the PICC line dressings are to be changed weekly and dated. During an interview on 3/10/2020 at 9:52 AM, with the Director Of Nursing (DON) she confirmed the PICC line dressings of Residents #58, #68, and #135 did not have a date or nurses' initials on the dressings. Continued interview she confirmed the dressings were not changed according to physician orders [REDACTED]. |
| F 0835<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Few | **Administer the facility in a manner that enables it to use its resources effectively and efficiently.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility policy review, facility documentation review, medical record review, and interview facility administration failed to recognize, report, and investigate an abuse allegation for 1 resident (Resident #33) reviewed for reporting an abuse allegation and failed to ensure the residents' Physician Orders for Scope of Treatment (POST) forms for 2 residents (Resident #6 and #49) reviewed for Advance Directives were accurately reflected in the resident's Electronic Medical Record (EMR) regarding the residents' Code status preferences, and failed to implement a Comprehensive care plan for [DIAGNOSES REDACTED] for 1 of 38 residents (Resident #77) reviewed for Comprehensive care plans. The facility's deficient practice placed 4 residents (Resident #33, #6, #49, and #77) of 91 residents reviewed in Immediate Jeopardy (a situation where the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) and had the potential to affect all residents in the facility. The Administrator, Director of Nursing (DON) and Regional Nurse Consultants were notified of the Immediate Jeopardy for the Advance Directives on [DATE] at 9:20 PM, for the Abuse on [DATE] 2020 at 7:31 PM, and for the Care Plan on [DATE] at 3:50 PM in the Administrator's office. The facility was cited Immediate Jeopardy at F-600 and F-678 were cited at a scope and severity of J, which is Substandard Quality of Care. The facility was cited Immediate Jeopardy at F-600, F-656, F-678, F-835, and F-867 were cited at a scope and severity of J. The Immediate Jeopardy was removed onsite and was effective [DATE] through [DATE]. An Immediate Action Removal Plan which removed the immediacy of the jeopardy, was received on [DATE] at 2:55 PM. The corrective actions were validated onsite by the surveyors on [DATE]. The findings include: Review of the facility policy, Abuse Prohibition Plan, revised [DATE], revealed .The facility has a zero-tolerance policy for abuse. Verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion is prohibited. The resident will not be subjected to mistreatment, neglect, exploitation or misappropriation of property. The facility will attempt to identify and will investigate any reported violation or allegation of abuse. Willful means the individual deliberately, not that the individual must have intended to, inflict injury or harm .reports of abuse, neglect, exploitation, misappropriation of resident's property and injuries of unknown origin are promptly and thoroughly investigated .The Administrator will investigate or assign the investigation to designated facility personnel such as the Director of Nursing. The investigation will begin immediately .abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Regulations and Law . Review of the facility policy, Advance Directives, revised on ,[DATE] revealed, .The facility representative will assist the resident as needed to communicate any changes in the residents Advance Directive to the physician and/or responsible party .The facility representative will discuss and provide written information explaining the Advance Directive Program, upon admission to the facility .The facility representative will periodically discuss the resident's Advance Directive to ensure the resident's wishes concerning end of life treatment have not changed . Review of the facility policy, Comprehensive Care Plan, revised ,[DATE], showed .The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team or in accordance with the resident's preferences and potential for discharge, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record . Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #33 was cognitively intact. Further review revealed the resident required 2 person total assist with transfers. Review of Resident #33's Physician Visit note dated [DATE] showed Resident #33 was having left shoulder pain and an X-ray was ordered. Review of Resident #33's Mobile Radiology report dated [DATE], showed, .Impacted nondisplaced left humeral fracture .NP (Nurse Practitioner) made aware . Review of Resident #33's Physician Visit note dated [DATE], showed Resident #33 had a contusion to her left arm and the X-ray showed fracture. Further review showed, .Send to Ortho (Orthopedic) Urgent Care for further evaluation of L (Left) Shoulder pain to eval (evaluation) and fx(fracture)/treatment . Review of Resident #33's ER Note dated [DATE] showed, .a tech was transferring her from her wheelchair to a bed 2 days ago. He tried to lift her under her arms. When this occurred she felt a pop in her left shoulder. She has had pain ever since then. It is sharp and throbbing, 10 out of 10 in severity, it is worse with movement. She has noticed some increased bruising, she denies any other injuries . During an interview on [DATE] at 9:05 AM, Resident #33 stated about 4 months ago I was lying in bed when (named CNA #1) came in and was going to get me up for bingo. He didn't have a lift and I told him 'No!' I'm not going without the lift. I asked him to please get the lift, but he wouldn't go get it. During further interview revealed CNA #1 proceeded to lift the resident by her arms to transfer her to a chair from the bed. Resident #33 stated, When he pulled me up, I heard a loud pop and I started having pain in my left arm. I told him it hurt, but he just said, 'You didn't break your arm!' Then he picked up my arm and moved it around and said, 'see' It really hurt when he did that. During further interview revealed Resident #33 informed the Director of Nursing (DON) the next day that CNA #1 did not use the lift when he attempted to transfer her and she insisted for him to use the lift, but he didn't and when he pulled her up by her arms she heard a pop and began to have pain in her left arm. During an interview on [DATE] at 4:19 PM with Nurse Practitioner #1 she stated the facility told her this injury was chronic. However on her [DATE]'s assessment she found fresh bruising and contusions on her left arm. That's when I |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445439 | A. BUILDING _____ B. WING _____ | 03/10/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| MT JULIET HEALTH CARE CENTER | 2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122 |

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) |
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| F 0835<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 6)<br>ordered for (named Resident #33) to be sent to Orthopedic Urgent care for further evaluation of left shoulder pain and fracture. During an interview on [DATE] at 4:51 PM with the Director of Nursing (DON) confirmed Resident #33 was a 2 person assist transfer with a mechanical lift, since admission. Further interview she stated Resident #33 felt CNA #1 was a little rough during the transfer when her arm was broken. During further interview the DON confirmed she was notified by Resident #33 on [DATE] that CNA #1 was rough with her during the attempted transfer on [DATE]. During an interview on [DATE] at 5:16 PM with the Administrator confirmed the incident involving Resident #33 was reported to her by the DON in [DATE] but was not considered abuse at that time. Refer to F-600, F-609, and F-610 Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment<br>dated [DATE], showed Resident #49 was cognitively intact. Review of the Physician Orders for Scope of Treatment (POST) for Resident #49 dated [DATE] located in the POST Form Book at the Nurses station showed the resident's code status was a DNR (Do not resuscitate). Review of Resident #49's EMR (Electronic Medical Record) showed the Code Status Ribbon (which displayed for quick reference at the top of the resident's EMR) was blank, which indicated the resident's code status was Full Code (Cardiopulmonary Resuscitation (CPR)). During an interview on [DATE] at 6:44 PM, with Licensed Practical Nurse (LPN) #6, who was assigned to Resident #49, she stated she would refer to the POST Form Book located at the nurses' station to determine a resident's code status. During an interview on [DATE] at 7:40 PM, Resident #49 stated he wanted CPR if his heart stopped and his decision had not changed since admission to the facility. Review of the medical record showed Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's Admission MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident #6's POST dated [DATE] located in the Post Form book showed the resident code status was Full Code. Review of Resident #6's EMR showed the Code Status Ribbon displayed an Advance Directive status of Do Not Resuscitate (DNR). During an interview on [DATE] at 5:43 PM with LPN #1, who was assigned to Resident #6, she stated she would look on the computer for a resident's code status. Further interview she stated, The code status is in bold right next to the resident's name on the computer. She then demonstrated this on the computer screen by opening the resident's EMR and pointing to the ribbon at the top of the screen where DNR was highlighted in yellow. During an interview on [DATE] at 6:27 PM with the Administrator confirmed code status on the POST forms for Resident #49 and Resident #6 conflicted with their code statuses in the EMR. Refer to F-678 Review of the medical record showed Resident #77 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data<br>Set ((MDS) dated [DATE] showed Resident #77 was severely cognitively impaired. Continued review revealed Resident #77 required tube feeding for nutrition. Review of the hospital History of Present Illness dated [DATE], showed .Today, the patient was altered and less interactive, and EMS (Emergency Medical Services) was called. EMS said they got a blood glucose of 12 at his home .the patient's core temperature was also found to be 91 degrees . Review of the Comprehensive Care Plan dated [DATE] showed Resident #77 had no care plan for [DIAGNOSES REDACTED] or for monitoring for signs and symptoms of [DIAGNOSES REDACTED]; length of time to hold tube feeding when residual was too high; and appropriate physician notification. Review of the progress note dated [DATE], showed, approximately 1435 (2:35 PM) resident became non responsive after having a second BM (bowel movement). Resident had been disconnected from tube feeding after checking residual and<br>having > (greater than) 110 ml residual (replaced) x's 2. NP (Nurse Practitioner) notified and gave orders to send resident out for evaluation and treatment. Medical record review of the vital signs dated for [DATE], revealed no documented blood sugar prior to transfer to the hospital by the facility. Review of the Emergency Patient Record dated [DATE], showed .Per EMS (Emergency Medical Service) The initial call was for an unresponsive PT (patient). Nurses at this facility saw that he went unresponsive 40 minutes. Our glucometer read L0 for us. We gave him D10 ([MEDICATION NAME] 10%) infusion. He's had a<br>low heart rate with 'us' and weak carotid pulses .Intraosseous special catheter (surgical steel IV (intravenous) catheter inserted directly into a patient's long bone in an emergency life threatening situation to provide rapid infusion of life saving medications/solutions) left tibia inserted at 1536 (3:36 PM) . Review of (Named Hospital) History of Present Illness dated [DATE], showed, .TF had reportedly been temporarily stopped D/T (due to) high gastric residuals/apparent constipation. He was also hypothermic -T-max 89 F (maximum temperature 89 degrees Fahrenheit). Had significant BM today however TF was never resumed . During an interview on [DATE] at 3:50 PM with the Director of Nursing (DON) she confirmed Resident #77 had a history of [REDACTED]. glucose level should have been monitored. Refer to F-656 During an interview on [DATE] at 2:00 PM with the Administrator confirmed she was the abuse coordinator. Further interview confirmed the incident for Resident #33 on [DATE] was not identified, reported, or investigated as an abuse allegation, and the advance directive preference inaccuracy for Resident #6 and Resident #49 were not identified until [DATE]. The Immediate Action Removal Plan, which removed the immediace of the Jeopardy, was received on [DATE] at 2:55 PM and corrective actions were validated onsite by the surveyors on [DATE]. The Immediate Action Removal Plan was verified by the surveyors on [DATE] by: 1. The surveyors verified through review of facility documentation dated [DATE], [DATE], and [DATE] QAPI meetings were held regarding Residents #6, #33, #49, and #77. 2. The surveyors verified the care plans with interventions were in place for 17 residents at risk for developing low blood sugar. 3. The surveyors reviewed the facility's abuse policy and verified there were no changes made to the policy. The facility's noncompliance at F-600, F-656, F-678, F-835, and F-867 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |
| F 0867<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on the facility's Quality Assurance Performance Improvement (QAPI) Plan review, policy review, medical record review, and interview, the QAPI committee failed to identify deficient practice for investigating allegations of abuse for 1 of 38 residents (Resident #33) reviewed for abuse; failed to identify no person centered care plan was implemented for 1 of 38 residents (Resident #77) reviewed for care plan implementation and interventions; and failed to identify the prescribed tube feeding formula was unavailable for 1 of 5 residents (Resident #77) reviewed for tube feedings which resulted in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The Administrator, Director of Nursing (DON) and Regional Nurse Consultants were notified of the Immediate Jeopardy on [DATE] 2020 at 7:31 PM. The facility was cited Immediate Jeopardy at F-600 and F-678 were cited at a scope and severity of J, which is Substandard Quality of Care. The facility was cited Immediate Jeopardy at F-600, F-656, F-678, F-835, and F-867 were cited at a scope and severity of J. The Immediate Jeopardy was removed onsite and was effective [DATE] through [DATE]. An Immediate Action Removal Plan which removed the immediacy of the jeopardy, was received on [DATE] at 2:55 PM. The corrective actions were validated onsite by the surveyors on [DATE]. The findings include: Review of the facility policy, Abuse Prohibition Plan, revised ,[DATE], revealed, .The facility has a zero-tolerance policy for abuse. Verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion is prohibited. The resident will not be subjected to mistreatment, neglect, exploitation or misappropriation of property. The facility will attempt to identify and will investigate any reported violation or allegation of abuse.Willful means the individual deliberately, not that the individual must have intended to, inflict injury or harm. Review of the facility's Quality Assurance Performance Improvement (QAPI) Plan dated ,[DATE] revealed, .The Quality Assurance Performance Improvement (QAPI) Plan is designed to establish and maintain an organized facility wide program that is data driven and utilizes a proactive approach to improving throughout the facility.The governing body and the facility administration shall provide general oversight for Quality Assurance and Performance Improvement activities related to resident care and services throughout the facility. Review of the facility policy, Comprehensive Care Plan, revised ,[DATE], showed .The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team or in accordance with the resident's preferences and potential for discharge, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. Review of the facility policy, Advance Directives, revised on ,[DATE], showed, .The facility representative will assist the resident as needed to communicate any changes in the resident's Advance Directive to the physician and/or responsible party.The facility representative will discuss and provide written information explaining the Advance Directive Program, upon admission to the facility.The facility representative will periodically discuss the resident's Advance Directive to ensure the resident's wishes |

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| F 0867<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 7)<br>concerning end of life treatment have not changed. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE],<br>showed Resident #33 was cognitively intact. Further review revealed the resident required 2 person total assist with transfers. Review of the Comprehensive Care Plan dated [DATE], showed, .Transfers-(Mechanical) Lift Assist. Review of Resident #33's Physician Visit note dated [DATE] showed Resident #33 was having left shoulder pain and an X-ray was ordered. Review of Resident #33's Mobile Radiology report dated [DATE], showed, .Impacted nondisplaced left humeral fracture.NP (Nurse Practitioner) made aware. Review of Resident #33's Physician Visit note dated [DATE], showed Resident #33 had a contusion to her left arm and the X-ray showed fracture. Further review showed, .Send to Ortho (Orthopedic) Urgent Care for further evaluation of L (Left) Shoulder pain to eval (evaluation) and fx(fracture)/treatment. Review of Resident #33's ER Note dated [DATE] showed, .a tech was transferring her from her wheelchair to a bed 2 days ago. He tried to lift her under her arms. When this occurred she felt a pop in her left shoulder. She has had pain ever since then. It is sharp and throbbing, 10 out of 10 in severity, it is worse with movement. She has noticed some increased bruising, she denies any other injuries. During an interview on [DATE] at 9:05 AM, Resident #33 stated about 4 months ago I was lying in bed when (named CNA #1) came in and was going to get me up for bingo. He didn't have a lift and I told him 'No!' I'm not going without the lift. I asked him to please get the lift, but he wouldn't go get it. During further interview revealed CNA #1 proceeded to lift the resident by her arms to transfer her to a chair from the bed. Resident #33 stated, When he pulled me up, I heard a loud pop and I started having pain in my left arm. I told him it hurt, but he just said, 'You didn't break your arm!' Then he picked up my arm and moved it around and said, 'see'.It really hurt when he did that. During further interview revealed Resident #33 informed the Director of Nursing (DON) the next day that CNA #1 did not use the lift when he attempted to transfer her and she insisted for him to use the lift, but he didn't and when he pulled her up by her arms she heard a pop and began to have pain in her left arm. During an interview on [DATE] at 4:19 PM with Nurse Practitioner #1 she stated the facility told her this injury was chronic. However on her [DATE]'s assessment she found fresh bruising and contusions on her left arm. That's when I ordered for (named Resident #33) to be sent to Orthopedic Urgent care for further evaluation of left shoulder pain and fracture. During an interview on [DATE] at 4:51 PM with the Director of Nursing (DON) confirmed Resident #33 was a 2 person assist transfer with a mechanical lift, since admission. Further interview she stated Resident #33 felt CNA #1 was a little rough during the transfer when her arm was broken. During further interview the DON confirmed she was notified by Resident #33 on [DATE] that CNA #1 was rough with her during the attempted transfer on [DATE]. During an interview on [DATE] at 5:16 PM with the Administrator confirmed the incident involving Resident #33 was reported to her by the DON in [DATE] but was not considered abuse at that time and an investigation was not done. Review of the medical record showed Resident #77 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] showed Resident #77 was severely<br>cognitively impaired. Continued review revealed Resident #77 required tube feeding for nutrition. Review of the hospital History of Present Illness dated [DATE], showed .Today, the patient was altered and less interactive, and E[CONDITION] (Emergency Medical Services) was called. E[CONDITION] said they got a blood glucose of 12 at his home. He was brought to the emergency room where D5 was started and the patient's mental status recovered quickly to baseline.the patient's core temperature was also found to be 91 degrees. Review of the Comprehensive Care Plan dated [DATE] showed Resident #77 had no care plan for [DIAGNOSES REDACTED] or for monitoring for signs and symptoms of [DIAGNOSES REDACTED]; length of time to hold tube feeding when residual was too high; and appropriate physician notification. Further review showed no new interventions were placed for monitoring signs and symptoms of [DIAGNOSES REDACTED] for Resident #77 after his return to the facility after his hospitalization on [DATE]. Review of the Nursing Notes dated [DATE], showed, Resident #77 was receiving [MEDICATION NAME] 1.5 at 40 ml/hr (milliliters per hour). Review of the progress note dated [DATE], showed, approximately 1435 (2:35 PM) resident became non responsive after having a second BM (bowel movement). Resident had been disconnected from tube feeding after checking residual and having > (greater than) 110 ml residual (replaced) x's 2. NP (Nurse Practitioner) notified and gave orders to send resident out for evaluation and treatment. Medical record review of the vital signs dated for [DATE], revealed no documented blood sugar prior to transfer to the hospital by the facility. Review of the Emergency Patient Record dated [DATE], showed .Per E[CONDITION] (Emergency Medical Service) The initial call was for an unresponsive PT (patient). Nurses at this facility saw that he went unresponsive 40 minutes. Our glucometer read L0 for us. We gave him D10 ([MEDICATION NAME] 10%) infusion. He's had a low heart rate with 'us' and weak carotid pulses.Intraosseous special catheter (surgical steel IV (intravenous) catheter inserted directly into a patient's long bone in an emergency life threatening situation to provide rapid infusion of life saving medications/solutions) left tibia inserted at 1536 (3:36 PM). Review of (Named Hospital) History of Present Illness dated [DATE], showed, .TF had reportedly been temporarily stopped D/T (due to) high gastric residuals/apparent constipation. Ultimately staff found resident unresponsive and checked BS (blood sugar) which read low. He was also hypothermic -T-max 89 F (maximum temperature 89 degrees Fahrenheit). Had significant BM today however TF was never resumed. During an interview on [DATE] at 3:50 PM with the Director of Nursing (DON) she confirmed Resident #77 had a history of [REDACTED]. glucose level should have been monitored. During an interview on [DATE] at 2:00 PM with the Administrator confirmed the incident involving Resident #33 was not recognized, reported and investigated as abuse but should have been and a person centered care plan was not implemented for Resident #77 to reflect the resident care needs. Further interview confirmed an AdHoc QAPI (an immediate Quality Assurance Performance Improvement Plan) meeting did not take place for these concerns until the IJ notification was given to them by the surveyors on [DATE]. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], showed<br>Resident #49 was cognitively intact. Review of the Physician Orders for Scope of Treatment (POST) for Resident #49 dated [DATE] located in the POST Form Book at the Nurses station showed the resident's code status was a DNR (Do not resuscitate). Review of Resident #49's EMR (Electronic Medical Record) showed the Code Status Ribbon (which displayed for quick reference at the top of the resident's EMR) was blank, which indicated the resident's code status was Full Code (Cardiopulmonary Resuscitation (CPR)). Review of Resident #49's Comprehensive Care Plan dated [DATE], showed a Code Status of Full Code. Review of Resident #49's Face Sheet, the Advance Directives section showed the directive was listed as Full Code. During an interview on [DATE] at 6:44 PM, with Licensed Practical Nurse (LPN) #6, who was assigned to Resident #49, she stated she would refer to the POST Form Book located at the nurses' station to determine a resident's code status. During an interview on [DATE] at 6:45 PM, LPN #7 stated she would refer the POST Form Book located at the nurses' station to determine for a resident's code status. During an interview on [DATE] at 7:40 PM, Resident #49 stated he wanted CPR if his heart stopped and his decision had not changed since admission to the facility. Review of the medical record showed Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #6's Admission MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident #6's POST dated [DATE] located in the Post Form book showed the resident code status was Full Code. Review of Resident #6's EMR showed the Code Status Ribbon displayed an Advance Directive status of Do Not Resuscitate (DNR). Review of Resident #6's Face Sheet, the Advance Directives section for showed the directive was listed as Do Not Resuscitate. Review of Resident #6's Care Plan dated [DATE] showed Resident #6's code status was DNR. During an interview on [DATE] at 5:43 PM with LPN #1, who was assigned to Resident #6, she stated she would look on the computer for a resident's code status. Further interview she stated, The code status is in bold right next to the resident's name on the computer. She then demonstrated this on the computer screen by opening the resident's EMR and pointing to the ribbon at the top of the screen where DNR was highlighted in yellow. During an interview on [DATE] at 6:27 PM with the Administrator confirmed code status on the POST forms for Resident #49 and Resident #6 conflicted with their code statuses in the EMR. During an interview with Registered Nurse (RN) #1 on [DATE] at 6:40 PM, who was assigned to Resident #6, he stated, If a resident coded (if the resident had no pulse and was not breathing) I would go to the computer and check the resident's code status. Further interview RN #1 stated, I can tell if a resident has a Full Code or DNR status by looking at the Code Status ribbon at the top of their EMR, it is in bold letters on the face sheet. Further interview RN #1 demonstrated obtaining Resident #6's code status by opening his computer and pointing to the ribbon at the top of the screen of Resident #6's EMR where DNR was highlighted in yellow. During an interview on [DATE] at 7:10 PM, with Admissions Clerk stated she was responsible to get the POST form signed by the resident and the doctor. Further interview revealed once the POST form was signed by the resident and the doctor, she would enter the code status selection in the computer. Further interview she stated if the resident was a full code the ribbon was blank and if the resident was a DNR it would display in yellow on the ribbon in the Resident's EMR. Further interview she stated she placed the original POST form in the POST form book at the nurses station. During an interview on [DATE] at |

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| F 0867<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 8)<br>8:19 PM, the Administrator confirmed staff were not to rely on the computer, but refer to the POST Form book located at the nurses' station for a resident's code status. Further interview confirmed the staff had not been educated on referring to the POST Form book, not the computer, for a resident's code status. During an interview on [DATE] at 10:00 AM, the Administrator stated Admissions personnel were responsible for getting a POST form signed by the resident and the doctor, putting the code status in the Resident's EMR, and putting the POST form in the book at the nurses' station. Further interview she stated the MDS nurse was to go to the POST book at the nurses' station to get a resident's code status for implementation of an Advance Directive care plan. Further interview confirmed this process did not happen for Residents #49 and #6. During an interview on [DATE] at 11:52 AM, MDS Coordinator confirmed she looked in the computer for the POST form she did not refer to the book at the nurses' station when implementing a resident's Advance Directive Care Plan. Further interview confirmed the code statuses on the POST forms for Resident #49 and #6 conflicted with the code status on their care plans. She stated, There was a process failure. REFER TO TAG #'S F-600, F-609, F-610, F-656, F-678, F-693, and F-835.<br>The Immediate Action Removal Plan was verified by the surveyors on [DATE] by: 1. The surveyors verified through review of facility documentation dated [DATE], [DATE], and [DATE] QAPI meetings were held regarding Residents #6, #33, #49, and #77. 2. Verified the care plans with interventions were in place for 17 residents at risk for developing low blood sugar. 3. The surveyors verified the facility's Incident Reporting System intake information regarding Resident #33 and CNA #1 was reported to the state agency on [DATE]. The facility's noncompliance at F-867 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. |