STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265720	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CREVE COEUR MANOR	1127 TIMBER RUN DRIVE SAINT LOUIS, MO 63146

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure two dependent residents (Residents #53 and #72) had their call lights within reach to allow them to call when they required staff assistance. The facility census was 99. 1. Review of Resident #72's most recent Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/14/20, showed the following staff assessment: -Understands others; -Usually understood; -Dependence on staff assistance for completion of his/her activities of daily living (ADLs). Review of the resident's comprehensive care plan for the area of ADL functional status, not dated, showed the resident needs assistance from one staff member. Review of the resident's care card showed the following: -Staff are directed to assist x 1 with all ADLs; -The resident self-propels in a wheelchair; -The resident is at risk for falls; -The resident is incontinent of bowel and bladder. Observation on 3/2/20 at 4:56 P.M. showed the resident sat in his/her wheelchair with his/her head slumped down to his/her chest, next to his/her bed. The resident said he/she would like to go to bed. The resident sat facing a bedside table and the wall behind it. The resident was not within reach of his/her call light that was wedged between the bedside table and the top drawer. The resident pointed to the call light, and the surveyor handed the call light to the resident. Observations on 3/3/20 at 1:32 P.M. showed the activities director wheeled the resident in his/her wheelchair from the dining room to his/her room. The resident's call light sat on the resident's bed, but not within reach of the resident. At 2:03 P.M., the resident remained seated in his/her wheelchair facing his/her bedside table and wall. The call light remained out of the resident's reach. The resident said he/she wanted to go to bed. At 3:20 P.M. and 4:46 P.M., the resident remained in the wheelchair at his/her bedside, with his/her head slumped down, and out of reach of his/her call light. Observation on 3/4/20 at 9:36 A.M., showed the resident sat in his/her wheelchair next to his/her bed, with his/her head slumped down to his/her chest. The resident said can I go to bed now? It's always like this. The resident sat out of reach of his/her call light that was wedged in his/her bedside cabinet drawer and not within reach of the resident. During an interview on 3/5/20 at 2:28 P.M., certified nurse aide (CNA) G said the resident is alert and oriented most of the time. The resident requires one staff for assistance with his/her ADLs and is able to voice his/her needs. During an interview on 3/6/20 at 11:27 A.M., CNA H said the resident is able to make his/her needs known and requires one staff assistance to use the toilet and with other ADLs. The resident does use his/her call light and will alert staff when he/she needs to have a bowel movement. 2. Review of Resident #53's most recent MDS, dated [DATE], showed the following staff assessment: -The resident had moderately impaired cognitive skills for daily decision making; -Required staff assistance for completion of his/her ADLs. Review of the resident's comprehensive care plan showed staff noted the resident had a history of [REDACTED]. Observation on 3/3/20 at 1:50 P.M., showed the resident sat in his/her wheelchair at the bedside. His/her call light was clipped to his/her bed on the right side of the resident, but he/she could not reach the call light. The resident said he/she has use of his/her right hand, but it doesn't extend out as normal. Observation on 3/4/20 at 9:31 A.M., showed the resident sat in his/her wheelchair next to his/her bed. The resident's call light was clipped to the resident's bed on his/her right side and behind his/her chair, out of reach. The resident asked the surveyor for his/her call light, so he/she could call for help. Observation on 3/5/20 at 9:06 A.M., showed the resident sat in his/her wheelchair next to his/her bed. The resident's call light was attached to the room dividing curtain behind the resident, and not in his/her reach. During an interview on 3/6/20 at 3:08 P.M., CNA J said the resident can make his/her needs known. The resident will use his/her call light or yell at people walking by his/her room to get assistance. The resident requires total care, except he/she feeds him/herself. During an interview on 3/6/20 at 4:14 P.M., CNA I said call lights should be in reach for all residents whether they are able to use the call light or not. During an interview on 3/6/20 at 5:30 P.M., the administrator and Director of Nurses (DON) said call lights should be in reach of all residents, regardless of if a resident uses the call light or not.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to ensure one resident's (Resident #77) physician's orders for his/her code status matched the resident's advance directive wishes and failed to ensure two residents' (Residents #65 and #307) current physician's orders listed the resident's code status. The facility census was 99. 1. Review of Resident #65's code status form in front of the medical record, dated [DATE], showed the resident wished to be a full code. Review of the resident's physician's order sheet (POS) dated [DATE]-[DATE] showed no code status listed on the resident's current physician's orders. 2. Review of Resident #77's Code Status Form in his/her medical record showed it is his/her choice to be a Full Code (Cardio [MEDICAL CONDITION] Resuscitation (CPR) would be performed if the resident's heart and/or breathing stopped). Review of the POS [REDACTED]. Review of Resident #307's Code Status Form in front of the medical record, dated [DATE], showed the resident's responsible party wished for the resident to have a code status of Do Not Resuscitate (DNR)/Do Not Intubate (No CODE). Review of the resident's physician's order sheet dated [DATE]-[DATE] showed an order for [REDACTED].M., the administrator and director of nursing (DON) said residents' code status should be listed on the resident's face sheet and physician's orders sheet. During an interview on [DATE] at 5:30 P.M., the administrator said if the resident or resident's responsible party indicated on the Code Status Form that the resident be a DNR, Social Services should follow up with the physician about changing their code status.
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, facility staff failed to complete a baseline care plan within 48 hours of admission and failed to document the baseline care plan was reviewed with the resident or responsible party for two residents (Residents #77, #241) out of 24 sampled residents. The facility census was 99. The administrator said the facility does not have a policy directing staff on completion of the baseline care plan. 1. Review of Resident #77's Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/3/20, showed staff assessed the resident as follows: -admission date of [DATE]; -Moderate cognitive impairment; -Total physical dependence of one staff for transfers, dressing, toileting,

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) personal hygiene, and bathing; -Extensive physical assistance of one staff for locomotion; -Limited physical assistance of one staff for eating; -Limited range of motion of the upper extremity on one side; -Always incontinent of bladder, frequently incontinent of bowel; -Occasional complaint of pain rated at a 4 in a scale of 0-10; -At increased risk for pressure ulcer with two Stage II ulcers and one Stage III ulcer; -During the seven day look back, took seven days of antidepressants and two days of antibiotics. Review of the resident's undated Interim/Baseline Care Plan, showed staff documented the following: -The resident uses a bedpan, urinal, assist for bladder; -The resident uses a bedpan and assist for bowel; -Regular diet. Further review of the resident's 48 hour baseline care plan, showed staff did not complete all areas of the baseline care plan, did not document problem start dates, initial goals based on admission orders [REDACTED]. Review showed the 48 hour baseline care plan was not dated, so it is unknown if it was completed in the required 48 hours. 2. Review of Resident #241's MDS, dated [DATE], showed staff assessed the resident as follows: -admitted [DATE]; -Moderate cognitive impairment; -Extensive physical assistance of one person for bathing; -Limited physical assistance of one person for transfers, walking, locomotion, dressing and personal hygiene; -Supervision and set up help for eating; -Supervision for toileting; -Always continent of bowel and bladder; -Occasional pain at a 4 on a 0-10 scale; -History of two non-injury falls; -No pressure ulcers. Review of the resident's undated Interim care plan, showed facility staff documented the following: -Bladder-commode; -Bowel-commode; -Regular diet. Further review of the resident's 48 hour baseline care plan, showed staff did not complete all areas of the baseline care plan, did not document problem start dates, initial goals based on admission orders [REDACTED]. Review showed the 48 hour baseline care plan was not dated, so it is unknown if it was completed in the required 48 hours. During an interview on 3/5/20 at 5:00 P.M., the administrator said a baseline care plan should be totally completed for a new admission. The administrator said he/she is responsible for completing the care plans, including the baseline care plan. The administrator did not have an alternate plan if a resident was admitted on the weekend. He/She said the charge nurse could complete the baseline care plan to provide direction to staff for the resident's care. The administrator did not have documentation to show the resident or responsible party received a copy of the care plan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to revise, review and/or update the comprehensive care plan for three residents (Residents #31, #44, and #46). Review of the facility's undated Comprehensive Care Plan Development policy and procedure, showed it is the policy of the facility to complete a comprehensive care plan for each resident requiring a Minimum Data Set (MDS) assessment and care area assessment (CAA) completion. 1) The care plan is based on the CAA process, which is required for Omnibus Budget Reconciliation Act (OBRA)-required comprehensive assessments. 2) After completing the MDS and CAA portions of the comprehensive assessment, the interdisciplinary team must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs. 3) A new care plan does not need to be developed after each annual assessment or significant change assessment, but the MDS and CAAs should be assessed for the need to modify or revise the current care plan. 4) The facility should also evaluate the appropriateness of the care plan after each quarterly assessment and modify the care plan on an ongoing basis, if appropriate. 1. Review of Resident #46's most recent Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/11/19, showed the following staff assessment of the resident: -Independent in cognitive skills for daily decision making; -Dependent on staff for completion of all his/her activities of daily living (ADLs); -One Stage IV pressure ulcer; no other pressure ulcers; -An unplanned weight loss. Review of the resident's plan of care showed the following: -The resident's wound care company's printed progress notes dated 2/7/20 and [DATE]; -A resident's wound care company's exit interview forms dated 9/30/19 and [DATE], that show a summary of each resident in the facility that the company visited on that date (including this resident), and a description of those residents' wounds; -MDS Care Area Assessment (CAA) Summary sheets dated 12/11/19 and 2/13/20; -A care plan for unplanned weight gain, dated 3/23/17, that directed staff in interventions to assist the resident in weight loss; -A care plan that address a planned weight loss, dated 1/21/19, that directed staff in interventions to assist the resident to not lose additional weight; -A care plan for unplanned weight loss, dated 2/20, that shows, My diet is (blank) and I have been placed on the following supplements: (blank); the plan directs staff in interventions to assist the resident to not lose additional weight; -Six different care plans that addressed pressure ulcers, some of which were noted to have healed. One dated 10/1/16 showed a pressure ulcer on the resident's right proximal posterior heel, with notation on 5/8/18 that the resident has no pressure ulcers at that time, and one dated 4/21/17 showed a pressure ulcer on the resident's left heel, with notation on 5/8/18 that the resident had no pressure ulcers. These plans were still part of the comprehensive care plan. All six of the plans addressed the same interventions for staff, except for one written in note that the resident refuses to lay down and wants to smoke. -One plan, undated, that addressed pressure ulcers on the right and left hip. Due to no date, it was not possible to show when the resident had the pressure ulcers and if staff should still be directed on the plan. -Eight pages of a care plan completed in a different format, some pages dated and others not, that appear to be the resident's initial plan of care created upon admission on 3/9/16. One plan, dated 3/9/16, directed staff in the resident's ADL needs, which included assistance for completion of the resident's ADLs, to hand the resident one item at a time, and to cue and allow resident to do as much for self as is safely able to do. Review of the resident's Care Card, which directs care staff use to provide care, showed staff were directed that the resident is total care, and his/her left arm is paralyzed. 2. Review of Resident #44's most recent MDS, dated [DATE], showed the following staff assessment: -Independent in cognitive skills for daily decision making; -No behavioral issues or rejection of care. Review of the resident's plan of care showed the following: -MDS CAA Summary sheets dated 12/13/19 and 2/28/20; -A plan dated 11/29/19, which noted the resident had behavioral disturbances including physically and verbally inappropriate and refuses care as evidenced by exposing him/herself to staff members of the opposite sex, refuses showers and curses at staff. The plan did not show the resident refused taking his/her medications when they are ordered to be given. The plan showed the resident would receive his/her medications as ordered by his/her attending physician and will be monitored for potential side effects as well as efficacy. Review of the resident's nurse's notes showed the following: -On 10/3/19, 11-7 shift, resident evening medications still at bedside; encourage to take all medications per order; -On 10/[DATE]9, 11-7 shift, medication left at bedside; -On 10/6/19, 11-7 shift, medication still on bedside table; encourage to take all medications; -On 10/8/19, 11-7 shift, resident has evening medications still at the bedside; encourage to take all meds; -On 10/10/19, shift not specified, medication left on bedside table; -On 10/11/19, shift not specified, medication left on bedside table; encourage to take all meds daily; -On 10/12/19, shift not specified, evening meds left on bedside table; -On 11/25/19, shift not specified, medication left on bedside table, resident encouraged to take his meds; very noncompliant with his/her medication; Observation on 3/4/20 at 9:46 A.M., showed the resident sat in a wheelchair in his/her room. A medicine cup containing multiple medications sat on the resident's bedside table. The resident said he/she had just finished dressing and would take his/her pills in a bit. The resident said staff brought the medications in during breakfast, and he/she just hadn't taken them yet. Observation on 3/5/20 at 9:35 A.M., showed the resident lay asleep in his/her bed. A medicine cup with multiple medications sat on the bedside table beside the resident. Staff were not present. 3. Review of Resident #31's most recent MDS, dated [DATE], showed the following staff assessment: -Moderately impaired cognitive skills for daily decision making; -Independent for completion of his/her ADLs; -Had two falls with no injury, one fall with an injury (not major) and one fall with a major injury (bone fracture, joint dislocation, closed head injury with altered consciousness, or subdural hematoma). Review of the resident's plan of care showed the following: -A CAA Summary dated 10/2/19; -Two different care plans for smoking; one dated 1/16/18 that showed the resident was assessed to be able to smoke with assistance only; one dated 2/[DATE]9 that showed the resident was assessed to be able to smoke independently. -A page that appeared to be a copy of a sign, dated for the resident's admission date of [DATE], directing staff to not let the resident leave the building with anyone. -Six pages of the resident's referral for services at the facility in 10/17, his/her intensive treatment plan dated 10/2/17, and a behavior contract dated 5/[DATE]8. -Two different care plans for falls, one dated 9/22/19 and one dated 2/20. The plans direct staff on the same interventions; -A plan of care to address falls, dated 2/20, with staff notes that the resident has many complaints of falls when he/she is with his/her family. The resident has been seen putting him/herself on the floor; -A plan of care for falls in a different format than the other fall plans, with updates dated 5/1[DATE]9 and

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 12/26/19. The 12/26/19 note showed the resident has a soft cast for three weeks on his/her right hand. This notation did not state that the resident fell in the shower room, nor any additional interventions to prevent a future fall while the resident showers him/herself. During an interview on 3/4/20 at 2:00 P.M., the resident said he/she broke her wrist with a fall in the bathroom while taking a shower. During an interview on 3/6/20 at 11:47 A.M., Licensed Practical Nurse (LPN) M said the resident fell in the shower room a while back; the LPN sent the resident out to the hospital due to a wrist injury. The LPN said staff only set up the resident's shower, and the resident is able to complete his/her shower his/her own. Review of a nurse's note dated 12/18/19 showed an x-ray was performed due to the resident falling in the bathroom. The resident was sent to the emergency department and returned on 12/19/19 with a orthopedic soft cast. During an interview on 3/5/20 at 10:38 A.M., LPN N said the charge nurse can update the care plans in the care plan book if they need to, but he/she would usually notify the Quality Assurance (QA) nurse or the administrator if changes needed to be made. The LPN does not know when the care plans are reviewed, who reviews them, if the care plans are signed and dated when they are reviewed. During an interview on 3/5/20 at 5:00 P.M., the QA nurse and the administrator said there is no documentation such as a sign in sheet to show when the care plans are reviewed and who reviewed them. The administrator said he/she is responsible for completing the care plans and keeping them updated, but it is very hard to keep up with in addition to his/her duties as an administrator. During an interview on 3/6/20 at 5:30 P.M., the administrator said she completes residents' care plans. She said the care plan should be an overall picture of the residents' needs. She thought adding residents' wound assessments and additional paperwork to the care plans helped to explain everything about the resident and their needs. Old care plan interventions were kept in the care plan to show all interventions that had been implemented. The administrator said ideally, a care plan should be updated after each fall, but right now, she has only been adding the number of falls a resident had in the month.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure they observed three residents (Residents #19, #28 and #44) take their medications, failed to ensure two residents (Residents #28 and #47) did not have inhalers left at their bedsides, and failed to apply the appropriate treatment to one resident's (Resident #53) pressure ulcer. The facility census was 99. 1. Observation on 3/3/20 at 4:48 P.M., showed Certified Medication Technician (CMT) K administered to Resident #28, the following medications: [REDACTED]. The CMT handed the resident a cup of the three medications, then left the resident's room and did not observe the resident take the medications. 2. Observation on 3/3/20 at 5:05 P.M., showed CMT K prepared medications for Resident #19 in the hallway outside the resident's room. The CMT popped [MEDICATION NAME] 1000 mg, one tablet into a cup and handed the cup to Resident #18 (Resident #19's spouse), and allowed Resident #18 to bring the cup of medication to Resident #19 who sat inside his/her room. The CMT did not observe that the resident received and took the medication. 3. Review of Resident #47's physician's orders [REDACTED]. The (POS) showed no order to allow the resident to self-administer his/her inhaler or any other medications. Observation on 3/5/20 at 9:00 A.M., showed CMT L administered the resident's morning medications. The CMT asked the resident if he/she had his/her inhaler, to which the resident said that he/she did. The CMT did not watch the resident use his/her inhaler. During an observation and interview on 3/6/20 at 9:54 A.M., the resident showed this surveyor his/her [MEDICATION NAME] Diskus inhaler in a drawer in his/her room. The resident said he/she uses the inhaler twice daily, without staff supervision. The resident also showed this surveyor an [MEDICATION NAME] inhaler (an inhaler used to relax muscles in the airway and increase air flow to the lungs) that the resident said he/she used as needed. 4. Review of Resident #28's POS, dated [DATE]-3/31/20, showed a physician's orders [REDACTED]. The (POS) showed no order to allow the resident to self-administer his/her inhaler or any other medications. During an observation and interview on 3/2/20 at 12:06 P.M., the resident sat in his/her recliner in his/her room. The resident's [MEDICATION NAME] Diskus inhaler sat on a chair next to the resident. The resident said staff leave the inhaler for him/her to use in his/her room. The resident said he/she uses the inhaler twice a day. 5. Review of Resident #44's POS, dated [DATE]-3/31/20, showed physician's orders [REDACTED]. Review of the resident's nurse's notes showed the following: -On 10/3/19, 11-7 shift, resident evening medications still at bedside; encourage to take all medications per order; -On 10/[DATE]9, 11-7 shift, medication left at bedside; -On 10/6/19, 11-7 shift, medication still on bedside table; encourage to take all medications; -On 10/8/19, 11-7 shift, resident has evening medications still at the bedside; encourage to take all meds; -On 10/10/19, shift not specified, medication left on bedside table; -On 10/11/19, shift not specified, medication left on bedside table; encourage to take all meds daily; -On 10/12/19, shift not specified, evening meds left on bedside table; -On 11/25/19, shift not specified, medication left on bedside table, resident encouraged to take his/her meds; very noncompliant with his/her medication. Observation on 3/4/20 at 9:46 A.M., showed the resident sat in a wheelchair in his/her room. A medicine cup containing multiple medications sat on the resident's bedside table. The resident said he/she had just finished dressing and would take his/her pills in a bit. The resident said staff brought the medications in during breakfast, and he/she just hadn't taken them yet. Observation on 3/5/20 at 9:35 A.M., showed the resident lay asleep in his/her bed. A medicine cup with multiple medications sat on the bedside table beside the resident. Staff were not present. 6. Review of Resident #53's most recent Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/2/20, showed the resident had one Stage II (a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister) pressure ulcer. Review of the resident's most recent plan of care addressing pressure ulcers, dated 12/9, showed the plan directed staff to refer the resident to a wound specialist. The plan did not direct staff to ensure appropriate treatment per the residents' physician's orders [REDACTED]. not exposed; slough may be present but does not obscure the depth of tissue loss; may include undermining and tunneling) to the right foot; the resident has a contracture to the ankle; site is currently treated with skin prep; -The wound was covered in 100% eschar intact scab, measuring 0.2 centimeters(cm) x 0.2 cm; -The onset date was 11/29/19; -The wound care company's plan included to continue skin prep for one more week. Review of the resident's current POS, dated [DATE]-3/31/20, showed a physician's orders [REDACTED]. Observation on 3/3/20 at 10:27 A.M., showed the director of nurses (DON) provided treatment to the wound on the resident's right foot. The DON said the physician ordered treatment was skin prep. The DON showed the surveyor a packet of skin protectant ointment, and opened and applied the skin protectant ointment to the wound in a thick layer. The DON did not wear gloves to apply the treatment, and did not apply the correct wound treatment per physician's orders [REDACTED].M., the administrator and DON said when giving medications, staff are expected to stay with the resident to ensure the resident takes the medications. It is not appropriate for staff to give a medication and not observe the resident take the medication. A resident should not have medication left at the bedside unless they have a physician's orders [REDACTED]. The DON said she is aware Resident #44 will not take his/her morning medications until he/she gets up out of bed later in the morning. The medications should not be left unattended at the resident's bedside. Staff are also expected to follow physician's orders [REDACTED].
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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, facility staff failed to provide adequate and appropriate perineal cleansing for two dependent residents (Residents #23 and #46) and failed to ensure good grooming for one resident's (Resident #72) fingernails. The facility census was 99. 1. Review of Resident #23's most recent MDS, dated [DATE], showed the following staff assessment: - Required extensive assistance from staff for dressing, toileting and personal hygiene; - Always incontinent of bladder; - Frequently incontinent of bowel; - diagnosed with [REDACTED]. Review of the resident's care plan, with multiple dates, showed the following: - The resident was at risk for pressure ulcers. Staff were directed to manage moisture (skin and incontinence management); - The resident was reluctant to perform personal hygiene without assistance. Staff were directed to assist as needed. Observation on 3/3/20 at 9:50 A.M., showed certified nurse aide (CNA) B provided care for the resident while the resident was in bed. The resident was incontinent of urine. CNA B used a wet washcloth to wipe the resident's lower back and buttocks and then wiped the perineal area from back to front. CNA B used a second wet wash cloth and again wiped the resident's lower back and buttocks and then wiped the perineal area from back to front. CNA B then used a towel to first dry the resident's lower back and buttocks and then the perineal area, wiping from

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) back to front. During an interview on 3/6/20 at 5:30 P.M., the director of nurses (DON) said she expected staff to wipe from front to back when cleansing a resident's perineal area. 2. Review of Resident #46's most recent Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/11/19, showed the following staff assessment: -Dependent on staff for completion of his/her activities of daily living (ADLs), including toileting and personal hygiene; -Incontinent of bowel; -Had a urinary catheter; -Had one Stage IV pressure ulcer. Review of the resident's plan of care showed the following: -An undated plan which directed staff on the management of his/her suprapubic catheter; the plan had one written in update dated 6/15/17 which stated the resident's suprapubic catheter was patent; -A plan for activities which showed a written intervention dated [DATE]/19 stating the resident is total care and needs assistance. Observation on 3/3/20 at 10:36 A.M., showed CNA G and CNA H provided care for the resident while in bed. CNA G used washcloths perineal cleansing spray for cleaning the resident's perineal area, but did moisten the washcloths before he/she sprayed the cleanser onto the cloth. CNA G wiped the resident's front while the resident lay on his/her back, by wiping down between the resident's legs without spreading the resident's legs. The CNA observed the cloth after wiping and with the last swipe, still showed brown smears. The CNAs turned the resident to his/her side, which showed the pad beneath the resident was wet with urine and smears of feces. The resident said he/she does have some urine leakage at times. CNA G wiped the resident's bottom with the dry cloth and perineal spray. The CNA cleansed the resident's right buttock and hip around his/her wound bandages, but did not cleanse the left buttock and hip. During an interview on 3/6/20 at 3:55 P.M., CNA I said the resident requires total care by staff. The resident has a suprapubic catheter, but dribbles some urine. The CNA said when cleaning a resident's perineal area, it is important to thoroughly clean all areas soiled with feces or urine. 3. Review of Resident #72's most recent MDS, dated [DATE], showed the following staff assessment of the resident: -Dependent on staff for his/her activities of daily living; -Incontinent of bowel and bladder. Review of the resident's plan of care for ADL functions, not dated, showed staff noted the following: -The resident is capable of performing partial hygiene and grooming without assistance; -The resident is reluctant to perform personal hygiene without assistance; -The resident requires assistance from one staff member for ADL completion. Observation on 3/2/20 at 4:56 P.M., showed the resident sat in his/her wheelchair. The resident's nails were long and exhibited brown debris beneath the length of the nails. Continued observations on 3/3/20 at 3:20 P.M. and on 3/4/20 at 9:36 A.M., showed the resident's fingernails remained with thick brown debris under the nails, which extended approximately one-quarter inch long, and the resident's hands and nails exhibited a foul, sour odor. Staff did not assist the resident to clean his/her nails until 3/5/20 at 9:08 A.M. During an interview on 3/6/20 at 11:27 A.M., CNA H said staff are directed to cleans residents' fingernails during showers and as needed to maintain good hygiene. During an interview on 3/6/20 at 5:30 P.M., the administrator and DON said when providing perineal cleansing, staff are expected to clean all areas soiled or wet. When using perineal cleansing spray, staff should moisten the washcloth prior to cleaning to avoid abrading the skin with a dry cloth. Staff are also expected to clean residents' fingernails during each shower and as needed in between. The activities staff also provide nail care as an activity.
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 and record review, facility staff failed to implement new interventions for one resident (Resident #66) after he/she resident had multiple falls. In addition, staff failed to follow the facility policy for falls. The facility census was 99. Review of the facility's Tracking Record for Improving Patient Safety (TRIPS), undated, showed the following: - It is the policy of this facility that a TRIPS form is completed on every resident experiencing a fall; - After evaluating and treating the resident immediately, the nurse should investigate the circumstances of the falls and look at all possible causes. All licensed nurses will be trained in the immediate fall response; - The Falls Nurse Coordinator will use the data recorded on the TRIPS form to identify trends related to types of falls. Such details include location, time and activity; - The nurse is still required to complete a narrative nurses note. 1. Review of Resident #66's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/14/20, showed staff assessed the resident as follows: - Moderately cognitively impaired; - Required limited assistance from staff for transfers, walking, dressing, toileting and personal hygiene; - Had two or more falls without injury since reentry. Review of the resident's care plan, documented as reviewed on 12/4/19, showed staff documented the resident had fallen due to an unsteady gait, dementia and weakness. Review showed staff documented the resident was very unsteady, had a stroke and used a cane. Review showed staff were directed to do the following: - Keep the call light and water within reach; - Answer my call light promptly; - Remind me to ask for assistance. Reorient me to the call light if necessary; - Ask me if I need to use the bathroom every two hours; - Encourage me to change positions slowly; - Keep my bed in the lowest position; - Assist me with all transfers; - Frequently reorient me to my surroundings as needed; - Visually check me at least every two hours; - Provide me a calm and quiet environment with reassurances; - Keep a small night light in my room; - Eliminate potential hazards, such as uneven surfaces, debris or water on the floor; - Put appropriate, nonskid footwear on me; - Ensure I am using assistive equipment appropriately if used; - Keep my assistive device within reach; - Ensure my assistive devices are appropriate to me; - Attend to me during activities of daily living; - Increase staff assistance and surveillance of me; - Evaluate me medically for causes contributing to my fall, such as postural [MEDICAL CONDITION], medication interaction, etc; - Address my pain issues if appropriate; - Evaluate me for skilled therapy services or restorative services if appropriate; - Provide me fluids and snacks as appropriate; - Allow me to rise naturally; - Staff to assist with toileting. Review of the nurses' notes showed staff documented the resident fell on the following dates: 12/14/19, 12/30/19, 1/30/20, 2/7/20, 2/22/20, 2/23/20 and one documented fall was undated and occurred at 3:10 A.M Review of the resident's chart showed the only TRIPS form that staff completed was for the fall on 1/30/20. Review showed staff did not complete a TRIPS form, as directed by facility policy, for the falls on 12/14/19, 12/30/19, 2/7/20, 2/22/20, 2/23/20 and the one documented fall which was undated and occurred at 3:10 A.M Review of the resident's care plan showed staff did not implement any new fall interventions after the resident began to have falls on 12/14/19. During an interview on 3/6/20 at 5:30 P.M., the Administrator said every time a resident falls the nurse is supposed to complete a TRIPS form. The administrator said ideally, a care plan should be updated after each fall, but right now, she has only been adding the number of falls a resident had in the month. MO 169
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** Based on interview and record review, the facility failed to ensure the Director of Nursing (DON) served as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. The facility census was 99. 1. Review of the Facility Assessment, dated June 2019, showed it did not address the DON serving as a charge nurse. Review of the facility's Daily Assignments schedule, dated [DATE] - 3/6/20, showed the DON was assigned to work as a charge nurse on the day shift on Monday, 3/2/20, and on on Tuesday 3/3/20. During an interview, the DON said he/she had been employed at the facility for two weeks. The DON said, in addition to occasionally working as the charge nurse for a shift, the DON covers the floor when a nurse must leave early in the morning or come in late in the evening. During an interview., the administrator said the DON often works on the floor as a charge nurse, including on 3/2/20 and 3/3/20. He/She was not aware the DON could not work as a charge nurse if the facility had 60 or more residents.
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, the facility staff failed to post the required daily nurse staffing hours in a prominent place readily accessible to residents. The facility census was 99. 1. Observation on 3/2/20 at 11:30 A.M., showed the nurse staffing hours posted on a bulletin board on the ground level of the facility across from the

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	265720	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	(continued... from page 4) timeclock. The staffing hours were posted at eye level when standing and could not be easily viewed from a sitting position, such as a from a wheelchair. Observation on 3/3, 3/4, 3/5, and 3/620, showed the 24 hour nurse staffing to be posted on a bulletin board on the ground level. Observation showed the 24 hour nurse staffing was not available to all residents on the Floor 1 and Floor 2. During an interview on 3/6/20 at 10:19 A.M., Certified Medication Technician (CMT) D said the nurse staffing information was posted by the timeclock on the basement level, but not on the second floor. During an interview on 3/6/20 at 5:30 P.M., the administrator and Director of Nursing (DON) said the 24 hour nurse staffing was only posted on the ground level and was not posted on Floor 1 and 2, where the residents reside. The administrator said the facility does not have a policy to direct staff on completion and posting of the 24 our nurse staffing form.
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being for one resident (Resident #241), when they did not evaluate the resident's usual patterns of behavior, did not document changes in the resident's behavior, did not document they informed the physician about changes in a resident's behavior, and did not implement individualized non-pharmacological interventions to address the resident's behavioral symptoms. The facility census was 99. Review of the facility's Behavior Management Policy, undated, showed the following: - It is the policy of this facility to identify behavioral symptoms using appropriate screening tools, manage behavioral symptoms appropriately and comply with regulatory requirements related to the use of medications to manage behavioral changes. Behavior can be a way for an individual in distress to communicate unmet needs, indicate discomfort or express thoughts that cannot be articulated; - Behavioral or Psychological Symptoms of Dementia (BPSD) describes behavioral symptoms in individuals with dementia that cannot be attributed to a specific medical or psychiatric cause. Current guidelines recommend the use of non-pharmacological interventions for BPSD; - As part of the comprehensive assessment, staff will evaluate, based on input from the resident, family and care givers, reviews of medical record and general observations the following: A. The resident's usual patterns of cognition, mood and behavior; B. The resident's usual method of communicating things like pain, hunger, thirst or other physical discomforts; C. The resident's typical or past responses to stress, fatigue, fear, anxiety, frustration and other triggers; - The nursing staff will identify, document and inform the physician about specific details regarding changes in an individual's mental status, behavior and cognition including: A. Onset, duration, intensity and frequency of behavioral symptoms; B. Any precipitating or relevant factors or environmental triggers; and C. Appearance and alertness of the resident and related observations; - New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others; - The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident's change in condition; - The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident and develop a plan of care accordingly; - Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs and strives to understand, prevent or relieve the resident's distress or loss of abilities; - Interventions and approaches will be based on a detailed assessment of physical, psychological and behavioral symptoms and their underlying causes as well as the potential situation and environment reason for the behavior. The care plan will include, at a minimum: - A. A description of behavioral symptoms including frequency, intensity, duration, outcomes, location, environment and precipitating factors or situations; - B. Targeted and individualized interventions for the behavioral and/or psychosocial symptoms; - C. The rationale for the interventions and approaches; - D. Specific and measurable goals for targeted behaviors; and - E. How the staff will monitor for effectiveness of the interventions; - Non-pharmacological approaches will be utilized to the extent possible to avoid or reduce the use of [MEDICAL CONDITION] medications to manage behavioral symptoms. 1. Review of Resident #241's Minimum Data Set (MDS), a federally mandated assessment tool, dated 2/17/20, showed staff assessed the resident as follows: - Severely cognitively impaired; - Had delusions; - Independent with bed mobility, transfers, and toilet use; - Required staff supervision for dressing and eating. Review of the resident's care plan, dated 2/3/20, showed staff documented the following: - The resident had cognitive loss related to dementia; - [CONDITION], paranoid aggression, falls, agitated, pacing, chews nails, thinks spouse is cheating, tearful, diabetic, behaviors, hypertension; - Review showed no specific behavior symptoms were documented and no individualized non-pharmacological interventions to prevent behavior symptoms. Review of the resident's nurses' notes showed staff documented the following: - [DATE] - The resident attempted to pick up a chair and throw it out the window. The resident stated that he/she wants out and is not supposed to be here. The psychiatrist was called and a new order was given to send the resident to the hospital for evaluation and treatment; - 2/17/20 - The resident returned to the facility from the hospital. - Review showed the last nurse's note documented for the resident was on 2/17/20. Review of the resident's Behavior Management Monthly Summary, dated February 2020, showed staff documented the resident was sent to hospital for behavior, no PRN (as needed) medications were used, a new intervention of sent out was added and this was successful in redirecting adverse behaviors. Staff document the resident is not currently seeing a psychiatrist and is not exhibiting any adverse reactions or side effect to any medications. Observation on 3/2/20 at 1:18 P.M., showed the resident walked quickly down the hallway while frequently looking behind himself/herself and crying. The resident briefly stopped in the dining room for approximately 30 seconds as residents ate lunch and staff assisted them. The resident had difficulty expressing what was wrong, but was able to state the man is coming to get me. He had the cord thing and I saw him and now he's trying to get me. The resident began to walk out of the dining room and down the hallway as he/she continued to cry and frequently looked behind himself/herself. Observation on 3/3/20 at 10:20 A.M., showed the resident in the hallway wringing his/her hands. The resident cried and quickly walked down the hallway. The resident said I need something to drink. I hope they don't get mad at me. I hope they are nice. Do you think they will get mad at me? The resident went into the dining room, sat in a chair, folded his/her arms and placed his/her head face down on his/her folded arms as he/she sobbed. Two staff were in the dining room, but did not address the resident until the state surveyor told them the resident was thirsty. Observation on 3/3/20 at 1:23 P.M., showed Resident #241 was not crying and assisted a resident as he/she pushed the resident's wheelchair down the hallway. An unidentified staff person told Resident #241 You can't be doing that, you can't push them. Resident #241 walked away from the wheelchair and out of the dining room. The resident began to cry and quickly walked down the hallway. During an interview on 3/3/20 at 3:45 P.M., the pharmacist said the resident seems very weepy today. She said the resident was not like that last month when she saw the resident. Observation on 3/3/20 at 5:35 P.M., showed the resident walked quickly down the hallway while crying. Observations on on 3/4/20, showed the following: - At 10:15 A.M., the resident walked quickly down the hallway while crying. The Corporate Nurse sat at the nurses' station. When the Corporate Nurse saw the resident, he/she got up from the nurses' station and tried to talk to the resident. The Corporate Nurse then asked a certified nurse aide (CNA) to do an activity with the resident; - At 10:25 A.M., the resident ran down the hallway crying. There was not a staff person with the resident. The Corporate Nurse again got up from the nurses' station and began walking down the hallway with the resident trying to calm him/her down. The resident began to walk down the hallway beside the Corporate Nurse instead of running; - At 10:29 P.M., the Corporate Nurse returned to the desk and told licensed practical nurse (LPN) A that the resident needed to be one on one right now; - At 10:35 P.M., the Corporate Nurse told LPN A to call the psychiatrist and tell him the resident has had all the medication they can have and the resident is still severely agitated; - At 10:40 A.M., LPN A placed a phone call and left a voice message for the physician to call him/her back about the resident. Continued observation at 10:41 showed LPN A continued to sit at the desk. A CNA was walking past the nurses' station holding the resident's hand as the resident cried. LPN A told the CNA to bring the resident closer to the nurses' station. LPN A went into the medication room and brought out a vial and a syringe. LPN A drew up medication from the vial and gave the resident an injection in the left upper arm as the resident put his/her head on the CNA's chest and sobbed. During an interview on 3/4/20 at 1:45 P.M., LPN A said the following: -When a resident's behavior reaches a level that he/she has to address it, then he/she calls the physician and documents this in a nurse's note. If they contact a physician this should be documented in a nurse's note along with what the physician's response is. Observation on 3/5/20 at 8:35 A.M., showed the resident walked quickly down the hallway while wringing his/her hands and crying. Observation at 8:49 A.M., showed the resident continued to walk quickly down the hallway while wringing

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) his/her hands and crying. The resident said They are after me as she sobbed. Observation on 3/5/20 at 8:56 A.M., showed the resident was walking past the nurses' station while crying and LPN A asked the resident to come closer to the nurses' station. LPN A drew up a medication from a vial with a syringe and needle and gave the resident an injection in the right arm. The resident then walked off alone and sobbing. Review of the resident's chart on 3/6/20 at 9:45 A.M., showed the Nurse Practitioner wrote an order dated 3/5/20 for [MEDICATION NAME] 5 mg daily as needed. Review showed the order did not clarify if the medication was to be given by mouth or injection. Review showed there was not an order for [REDACTED]., LPN E said he/she could not find an order written [REDACTED]. During an interview on 3/6/20 at 10:30 A.M., LPN A said the following: - The injection he/she gave the resident on 3/4 and 3/5/20 was [MEDICATION NAME]; - He/she is unsure why there was not an order for [REDACTED]. He/she obtained the [MEDICATION NAME] from the emergency medication kit. The resident had to have the [MEDICATION NAME], because he/she was walking the floors crying hysterically; - He/she does not think he/she has ever charted anything about the resident's behavior symptoms. The resident's spouse calls about 20 times a day, so there is not time to sit down and write a long nurse's note about the resident. During an interview on 3/6/20 at 5:30 P.M., the Administrator said if a resident has an increase in behavior symptoms then staff should contact the physician and document this in a nurse's note along with any new orders received from the physician and what interventions they tried to address the increase in behavior symptoms before they called they physician.
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 observation, interview and record review, the facility staff failed to ensure one resident (Resident #16) was not given [MEDICAL CONDITION] medication unless necessary, when they started the resident on [MEDICATION NAME] (an antipsychotic), after the hospital directed this medication be discontinued, increased the dose of this medication from 12.5 mg to 50 mg without any indications to do so, and did not address a pharmacist's recommendation to clarify the dose of the [MEDICATION NAME]. Additionally, the facility staff failed to perform Gradual Dose Reductions (GDRs) on [MEDICAL CONDITION] medications in accordance with Centers for Medicare & Medicaid Services (C[CONDITION]) guidelines for one resident (Resident #78). The facility census was 99. Review of the facility's Antipsychotic Medication Use Policy, dated 2015, showed the facility will attempt to taper [MEDICAL CONDITION] medication use in at least two separate quarters with at least one month between attempts, unless clinically contraindicated, during the first year. This will occur for both residents who are admitted from the community or transferred from a hospital and who are already receiving [MEDICAL CONDITION] medications that have been initiated by the facility. 1. Review of the Resident #16's Minimum Data Sets (MDSs), a federally mandated assessment tool, dated 2/13/18, 5/30/18, 8/7/18, 11/9/18, 2/12/19 and 5/15/19, showed staff assessed the resident did not receive an antipsychotic medication. Review of the resident's MDS, dated [DATE], showed staff assessed the resident as follows: - Severe cognitive impairment; - Did not have hallucinations, delusions, behavioral symptoms, rejection of care or wandering; - Totally dependent on staff for locomotion, dressing and hygiene; - Required extensive assistance from staff for transfers and toileting; - Required limited assistance from staff for eating; - Always incontinent of bowel and bladder; - diagnosed with [REDACTED]. Review of the resident's Physician order [REDACTED]. Review of a nurses note, dated 10/11/19, showed staff documented the resident was involved in a resident to resident altercation, was sent to the hospital and admitted to the ICU for a frontal lobe contusion. Review of the discharge paperwork from the hospital showed the following: - A discharge summary, signed on 10/15/19 at 4:12 P.M., that directed the resident was to continue taking [MEDICATION NAME] 12.5 mg by mouth at bedtime; - A discharge summary, signed on 10/15/19 at 4:29 P.M., that directed the resident was to discontinue taking [MEDICATION NAME]; - A Post Acute Care Handoff from the hospital, printed 10/15/19 at 6:17 P.M., that directed the resident was to discontinue [MEDICATION NAME] 12.5 mg by mouth daily at bedtime. Review of the FDA website shows [MEDICATION NAME] has a black box warning (appears on the label of a prescription medication to alert consumers and healthcare providers about safety concerns, such as serious side effects or life-threatening risk; is the most serious medication warning required by the U.S. Food and Drug Administration) which states that there is an increased risk for mortality in elderly patients with dementia when this medication is given. Review of the resident's POS, dated 10/15/19 through 10/31/19, showed the following: - Staff documented an order for [REDACTED]. Staff documented they gave this medication 13 out of the remaining 17 days of October. Review of a Medication Regimen Review found in the resident's chart, dated 10/17/19, showed the pharmacist documented a potential clinically significant medication issue was found. The pharmacist documented Hospital discharge summary has [MEDICATION NAME] 12.5 mg HS and POS has 50 mg HS. Please clarify dose. Review showed there was a spot on the form titled Facility Response and it was blank. Review of the resident's POS, dated 11/1/19 through 11/30/19, showed an order for [REDACTED]. Review of the resident's POS, dated 12/1/19 through 12/31/19, showed an order for [REDACTED]. Review of the resident's POS, dated 1/1/20 through 1/31/20, showed an order for [REDACTED]. Review of the resident's POS, dated 2/1/20 through 2/29/20, showed an order for [REDACTED]. Review of the resident's POS, dated [DATE] through 3/31/20, showed an order for [REDACTED].M. of the resident's MAR, dated March 2020,showed an order for [REDACTED]. Review of the resident's nurses' notes from 10/15/19 through 3/5/20, showed there was not any documentation of hallucinations, delusions, behavior symptoms, rejecting care or wandering. In addition, review showed no notes documented about the Medication Regimen Review from the pharmacist, dated 10/17/19, asking for clarification of the [MEDICATION NAME] dose. Observation on 3/2/20 at 11:45 A.M., showed the resident lay in bed quietly with his/her eyes closed. Observation on 3/4/20 at 11:23 A.M., showed the resident lay in bed quietly with the comforter over his/her head. Observation on 3/4/20 at 8:45 A.M., showed CNA B assisted the resident to walk from the dining room to his/her room. Certified Nurse Aide (CNA) B provided care to the resident and assisted the resident to lay down in bed. The resident lay in bed quietly with his/her eyes closed. During an interview on 3/5/20 at 10:50 A.M., CNA B said the resident naps all the time, but does come out of his/her room for activities and eats good. During an interview on 3/5/20 at 1:55 P.M., the quality assurance (QA) nurse said the former assistant direction of nurses (ADON) left about a month ago, but before she left she was in charge of the follow through with the pharmacy recommendations. The director of nurses (DON) is in charge of this now. During an interview on 3/5/20 at 2:00 P.M., the Corporate Nurse said the pharmacy gives their recommendations to the ADON and the ADON communicates the recommendation to the physician. Usually, they require these recommendations be addressed within three days. The former ADON had promised she had taken care of the pharmacy recommendations. Upon review though, they found she had not been following up on the pharmacy reviews in January and February. The DON was then delegated to take over the pharmacy recommendations task, but she didn't and she left about a week ago. Observation on 3/5/20 at 3:07 P.M., showed the resident lay in bed quietly with his/her eyes closed. Observation on 3/6/20 at 10:07 A.M., showed the resident lay in bed quietly with his/her eyes closed. During an interview on 3/6/20 at 10:00 A.M., the resident's attending physician said he did not recall if staff contacted him about the resident's antipsychotic medication. During an interview on 3/6/20 at 5:30 P.M., the administrator said when a resident comes to them from a hospital, the nurse verifies the discharge hospital medication list with the resident's physician at the facility and then writes the ordered medications on the MAR. If a nurse has a question about a medication then they should contact the resident's physician. The DON and ADON review orders for new admissions and readmissions the morning after the resident enters the facility. 2. Review of Resident 78's quarterly Minimum Data Set (MDS), a federally mandated resident assessment tool, dated 1/9/20, showed staff assessed the resident as follows: -Severe cognitive impairment; -Total physical dependence of one person for toileting, personal hygiene, dressing, and bathing; -Extensive physical assistance of one person for eating; -Limited physical assistance of one person for bed mobility, transfers, walking, and locomotion; -Always incontinent of bowel and bladder; -[DIAGNOSES REDACTED]. Review of the resident's Physician Order's Sheet (POS), dated [DATE] - 3/31/20, showed orders for the following [MEDICAL CONDITION] medications; -[MEDICATION NAME] 0.5 milligrams (mg) by mouth two times daily; -[MEDICATION NAME] 37.5 mg by mouth daily; -[MEDICATION NAME] 25 mg by mouth three times daily. Review of the resident's progress notes on 3/5/20, showed the pharmacist reviewed the resident's medications on

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 6) 2/1/19 and made recommendation to reduce the [MEDICATION NAME] from 0.5 mg two times daily and to reduce the [MEDICATION NAME] from 75 mg to 37.5 mg. A GDR recommendation for [MEDICATION NAME] was not located in the resident's record. During an interview on 3/5/20 at 10:30 A.M., the administrator said he/she expected a GDR to be recommended by the pharmacist and evaluated by the physician as directed by C[CONDITION]. The administrator contacted the pharmacist and he/she said recommendations for a [MEDICATION NAME] GDR had been made but the physician had not followed through. He/She does not know where those recommendation forms are. The administrator was unable to find them in the DON's office or in medical records.
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to ensure they administered medications with an error rate of less than five percent. Facility staff made two errors of a total of 32 medications passed, yielding an error rate of 6.25%. The facility census was 99. 1. Review of Resident #18's physician's orders [REDACTED]. Review of potential side effects of [MEDICATION NAME] include upset stomach, nausea, vomiting, heartburn, diarrhea constipation, and serious gastrointestinal effects including bleeding, ulceration and perforation of the stomach or intestines. Observation on 3/3/20 at 5:07 P.M., showed Certified Medication Technician (CMT) K administered to the resident, his/her [MEDICATION NAME] tablet in the resident's room without any food. Review of the facility's dining times showed dinner was served starting at 5:30 P.M. During an interview on 3/6/20 at 5:30 P.M., the administrator and Director of Nurses (DON) said if a medication is ordered to be given with food, then the medication should be given with food or a snack. 2. Review of Resident #47's POS showed a physician's orders [REDACTED]. Observation on 3/5/20 at 9:00 A.M. showed CMT L administered the resident's morning medications. The CMT asked the resident if he/she had his/her inhaler, to which the resident said that he/she did. The CMT did not watch the resident use his/her inhaler. Review of the resident's Medication Administration Record [REDACTED]., showed CMT L documented he/she administered the resident's inhaler to the resident. During an interview on 3/6/20 at 9:54 A.M., the resident showed this surveyor his/her [MEDICATION NAME] Diskus inhaler in a drawer in his/her room. The resident said he/she uses the inhaler twice daily, without staff supervision. The resident also showed this surveyor an [MEDICATION NAME] inhaler (an inhaler used to relax muscles in the airway and increase air flow to the lungs) that he/she uses as needed. During an interview on 3/6/20 at 5:30 P.M., the administrator and DON said a resident should not have medication left at the bedside unless they have a physician's orders [REDACTED].

F 0760 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one resident (Resident #307) was free of significant medication errors when they failed to obtain and administer two [MEDICAL CONDITION] medications as ordered by the physician for approximately one month. The facility census was 99. 1. Review of the resident's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 2/4/20, showed staff assessed the resident as follows: -Cognitively intact; -Had delusions; -Rejected care; -Independent with bed mobility, transfers, walking, dressing, eating, toilet use and personal hygiene; -Continent of bowel and bladder; -diagnosed with [REDACTED]. Review of hospital discharge papers showed the following: -The resident was admitted for inpatient psychiatric treatment on 1/13/20 and discharged on [DATE]; -The admitting [DIAGNOSES REDACTED]. Review of the resident's medical record showed prescriptions, dated 2/4/20, written by the hospital psychiatrist for [MEDICATION NAME] 300 mg by mouth twice daily and [MEDICATION NAME] 20 mg by mouth daily at bedtime Review of the resident's Physician order [REDACTED]. Review of the resident's Medication Administration Record (MAR), dated February 2020, showed staff not did transcribe the order for [MEDICATION NAME] or [MEDICATION NAME] from the POS. Review of nurses' notes, for February 2020, showed the following: -2/22/20 at 12:00 A.M. - Resident walking back and forth through the hallways hitting on doors stating she is going to wake everybody up because staff will not get him/her a soda; -2/22/20 at 1:00 A.M. - The resident continues walking the halls hitting on doors; -2/22/20 at 1:35 A.M. - The psychiatrist was called and made aware of resident's behavior. The psychiatrist gave orders to send the resident to the hospital for a psychiatric evaluation. The administrator and the resident's family were called. The ambulance transported the resident to the hospital; -2/22/20 at 1:30 P.M. - The resident arrived back to the facility by ambulance from the hospital. The resident has no new orders. Review of the resident's POS, dated [DATE] through 3/31/20, showed the following: -an order for [REDACTED]. Review of the resident's March 2020 MAR, on 3/4/20 at 2:30 P.M., showed the following: -an order for [REDACTED]. This medication was documented as not given twice on 3/1, once on 3/2, twice on 3/3 and once on 3/4. -Staff documented for 3/1 that the [MEDICATION NAME] was not given need to call doc for refill. -Staff documented for 3/3 that the resident refused all morning meds. -Staff documented for 3/4 that the [MEDICATION NAME] was not given needs refill/CN (charge nurse) handling. -an order for [REDACTED]. This medication was documented as given on 3/1 and 3/2. This medication was documented as not given on 3/3; -Staff documented for 3/3 that the resident refused all night meds. During an interview on 3/2/20 at 11:55 A.M., the resident said he/she has lived at the facility for about three weeks. The resident became tearful and said the facility is not giving him/her the correct medication. He/She said They are not giving me my [MEDICATION NAME] so I can't sleep and I'm not eating. Observation on 3/3/20 at 1:05 P.M., showed the resident upset in the hallway and speaking very loudly. The resident said people needed to listen to him/her, because there are people sick and dying on television. The resident walked into the dining room and went up to an unidentified staff person who was feeding another resident and begged the staff member to come back to his/her room to listen to the TV. The unidentified staff person pulled another chair up to the table and asked the resident to please sit down. The resident sat down for approximately one minute and then got back up and proceeded to go down the hallway speaking loudly about the TV talking to him/her. Observation on 3/3/20 at 1:45 P.M., showed the resident rapidly pacing through the hallways asking multiple people for batteries. The resident said if he/she got it to work then he/she could plug it into the elevator to leave. During an interview on 3/3/20 at 2:00 P.M., Licensed Practical Nurse (LPN) A said Medicaid would not pay for the resident's [MEDICATION NAME]. LPN A said if the resident was on [MEDICATION NAME] then he/she wouldn't be acting like this. Observation on 3/3/20 at 2:25 P.M., showed the resident in the phone room with the door open. The phone room was the first room down the hallway from the nurses' station. The resident was yelling into the phone that he/she was [MEDICAL CONDITION] and staff won't give him/her the correct medication. The resident yelled into the phone while sobbing, Nobody is paying attention to me! They don't care, nobody cares and I'm going crazy, because they aren't giving me my medicine! I'm going crazy, the TV is talking to me! I won't take the medicine they give me, because it's not right! Observation showed an unidentified staff person sat at the nurses' station charting. The unidentified staff person said the resident was on the phone with state and that this was the second time the resident had called them today. The unidentified staff member stated the resident had been like this since admission, but it was worse today, because the resident had refused medication the past two days. The resident yelled out the doorway of the phone room to the state surveyor and asked the state surveyor to come in and talk to the person on the phone. The resident yelled, Tell them what is happening! as he/she cried and handed the phone to the state surveyor. The resident had called the emergency mental health hotline. During an interview on 3/3/20 at 2:46 P.M., LPN A said the resident has been off [MEDICATION NAME] for about a week and they found out about three days ago. LPN A said as soon as they found out they started trying to order it. During an interview on 3/3/20 at 3:18 P.M., the pharmacist said she was not sure if she looked at the resident's chart last month, because the resident may have been admitted right after she was there to do her chart reviews. Staff told her that for the past couple of days the resident was refusing medication. The pharmacist said she would look into whether or not the resident was getting the ordered dose of [MEDICATION NAME]. During an interview on 3/3/20 at 3:52 P.M., the pharmacist said the following: -She looked for [MEDICATION NAME] for the resident in the medication cart, but did not find any. She called the person who does billing at her company who said they have not dispensed [MEDICATION NAME] or [MEDICATION NAME] to the facility for the resident, because Medicaid required additional documentation from the resident's physician since the resident was on more than six [MEDICAL CONDITION] medications. She was going to notify the administrator. During an interview on 3/4/20 at 1:45 P.M., LPN A said the following: -He/she had only worked at the facility for two weeks; -When the resident does not sleep, he/she hallucinates and is not rational; -When a resident's behavior reaches a level that he/she has to address, then he/she calls the physician and documents this in a nurse's note. If they contact a physician this should be documented in a nurse's note along with what the physician's response is; -The admission process for admission orders [REDACTED]. Staff write out the hospital discharge medication list on a POS. The nurse verifies the orders by calling the resident's attending physician at the facility. After the physician verifies the orders, the nurse writes the ordered medications on the MAR; -He/she does not think the resident received any [MEDICATION NAME] during February. The Certified Medication Technician (CMT) would be the one to give the resident [MEDICATION NAME]. The first time he/she was made aware that the resident was not receiving

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F 0760 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 7) [MEDICATION NAME] was three days ago when CMT C told him/her about it. CMT C was comparing the February MARs to the March MARs on 2/29/20 and noticed there was an order for [REDACTED]. When CMT C found this, they faxed the order for the [MEDICATION NAME] to the pharmacy. He/she then received a call from the pharmacy saying the reason they had not filled the [MEDICATION NAME] order was that there had to be a prior authorization from the resident's physician for the medication. He/she did not notify the physician the resident was not receiving [MEDICATION NAME]; -He/she did not know the resident was not getting his/her ordered [MEDICATION NAME] until today. During an interview on 3/4/20 at 2:11 P.M., CMT C said the following: -The resident seems to be aware of the medications he/she receives. The resident kept telling staff that they were not giving him/her all of his/her medications and some days the resident would refuse medication because of this; -Once the March MARs came out, he/she noticed there was an order for [REDACTED]. During an interview on 3/4/20 at 2:45 P.M., the Administrator said the following: -They were not aware the resident was not receiving the ordered [MEDICATION NAME] and [MEDICATION NAME]. The pharmacist notified them of this yesterday evening. The pharmacist told them that they tried to contact the facility four times because Medicaid required additional documentation from the resident's physician before they would pay for the medication, but she was not aware of this until yesterday evening; -They contacted the resident's attending physician and psychiatrist today to notify them the resident had not been receiving the ordered [MEDICATION NAME] and [MEDICATION NAME] and this was the first time the physicians were made aware of this; -They contacted Medicaid today about what is required before they will pay for the [MEDICATION NAME] and [MEDICATION NAME]. Until Medicaid is able to pay for the medication the facility will pay for it. During an interview on 3/4/20 at 4:24 P.M., the attending physician for the resident said the following: -He is uncertain if he saw the resident yet or if someone else in his office had; -He does not recall if staff contacted him about [MEDICATION NAME] and [MEDICATION NAME] being unavailable for the resident; -If a medication is not available for a resident he expected staff to notify him, or the psychiatrist if it is a [MEDICAL CONDITION] medication, so a possible substitute medication can be ordered; -He cannot say for sure what effect not getting the [MEDICATION NAME] and [MEDICATION NAME] since admission had on the resident. The behaviors they told him the resident had yesterday sounded like [MEDICAL CONDITION] to him. During an interview on 3/6/20 at 10:40 A.M., LPN A said the resident never told him/her that he/she wasn't getting [MEDICATION NAME], but the resident did tell him/her that he/she wasn't getting the correct medications. During an interview on 3/6/20 at 5:30 P.M. the Administrator said the following: -When a resident is admitted to them from the hospital the admitting nurse verifies the medication list from the hospital with the attending physician. After this, the nurse writes the medication orders on the POS and also on the MAR; -If the nurse has a question about a resident's medication orders then they should contact the physician; -If the nurse calls the physician then they should document this in a nurse's note and include what they told the physician and any new orders the physician gave; -Nobody does 24 hour chart checks at the facility; -The director of nurses (DON) and quality assurance (QA) nurse review orders for new admissions and readmissions the day after admission.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, facility staff failed to label and store medications in an appropriate manner when they failed to date [MED] and multi-use vials on the date the vials were opened, failed to ensure medication carts were free of loose pills, and failed to discard expired medications. The facility census was 99. 1. Observation on 3/5/20 at 10:17 A.M., of the medication room on the first floor of the facility showed the following: In an upper storage cabinet: -A 100 count box of [MEDICATION NAME] suppositories (laxative) with an expiration date of 9/19; -A four ounce bottle of Ultra tuss cough suppressant [MEDICATION NAME] with an expiration date of 9/19; -A 100 count box of mucus relief [MEDICATION NAME] (reduces chest congestion) 400 mg, with an expiration date of 12/19; -A one-half ounce bottle of ear drops earwax removal aide with an expiration date of 10/19; -A 16 ounce bottle of iron supplement [MEDICATION NAME] sulfate 220 mg with an expiration date of 1/20. In a medication refrigerator: -A bottle of Brisk lemonade stored in the freezer portion of the refrigerator; -An opened vial of influenza vaccine with no date written on the bottle or box to show when it was opened; -Nine [MEDICATION NAME] suppositories with an expiration date of 9/19; -An opened vial of [MEDICATION NAME] ([MEDICATION NAME] 10 test) in a bag, with no date written on the bottle or bag to show when it was opened; -A one-half milliliter vial of [MEDICATION NAME] 23 (vaccine to protect against pneumococcal disease), ordered for a specific resident who no longer resides in the facility, dated 11/19/18. 2. Observation on 3/5/20 at 1:30 P.M., of the first floor Certified Medication (CMT) medication cart showed the following in the top drawer of the cart: -A 100 count floor stock bottle of acidophilus [MEDICATION NAME]([MEDICATION NAME]), with an expiration date of 1/20; -Twelve loose tablets, varied in size and color; -An opened vial of [MEDICATION NAME]ordered for Resident #19, with no date written to show what date it was opened; -An opened vial of humalog [MED] ordered for Resident #293 with no date written to show what date it was opened; -An opened vial of sterile water for injection with no date written to show what date it was opened. 3. Observation on 3/5/20 at 1:50 P.M. of the second floor CMT medication cart showed the following: In the top drawer: -A floor stock 100 count bottle of [MEDICATION NAME] 5 mg, with an expiration date of 2/20; -A bottle of folic acid (a type of B vitamin) 400 micrograms, with an expiration date of 7/19; -Two loose tablets, of different size and color; -A medication cup with three pills, not labeled with the content of the cup nor the name of the resident to which they belonged; In the bottom drawer: -A 90 count floor stock bottle of fiber laxative calcium polycarbophil 625 milligrams (mg), with an expiration date of 9/19; -A bottle of fish oil, 500 mg, with an expiration date of 10/19; -A 16 ounce bottle of liquid pain relief [MEDICATION NAME] 160 mg/5 ml, with an expiration date of 12/18; -A 16 ounce bottle of ultra tuss [MEDICATION NAME], with an expiration date of 10/19. During an interview on 3/6/20 at 5:30 P.M., the administrator and director of nurses said staff are expected to write the date on medication vials when they are opened, so they can be discarded within the recommended time frame. The CMT or nurse using a medication cart or medication room should routinely check for expired medications and discard them as needed.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, facility staff failed to adequately clean and disinfect multi-use blood glucose meters between resident use and failed to clean vials of [MED] prior to removing [MED] for injection for one resident (Resident #19). The facility census was 99. 1. Observation on 3/3/20 at 4:57 P.M., showed Certified Medication Technician (CMT) K obtained the multi-use blood glucose meter from a container in the top drawer of the CMT medication cart. The CMT did not clean the machine before he/she used the machine to check Resident #19's fingerstick blood glucose level. After obtaining the blood glucose result, the CMT placed the blood glucose meter back into the top drawer of the medication cart without cleaning the meter. The CMT then obtained the resident's Levimir [MED] and the resident's [MEDICATION NAME]bottles from a container in the top drawer of the medication cart which held multiple other residents' [MED] bottles, and drew up the doses of [MED] without first cleaning the tops of the vials. Observation on 3/5/20 at 4:10 P.M., showed CMT D obtained the multi-use blood glucose meter from the container in the top drawer of the medication cart. The CMT did not clean the machine before he/she used the machine to check Resident #19's fingerstick blood glucose level. After obtaining the blood glucose result, the CMT took a single packaged alcohol wipe and swiped the wipe around the blood glucose meter for approximately five seconds, then placed the meter back into the medication cart. Review of the manufacturer's instructions for cleaning and disinfecting the type of blood glucose meter used, showed the following: -To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended in the instructions; -The (brand name) blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed; -An Environmental Protection Agency (EPA) registered disinfectant product may be used to clean and disinfect the blood glucose meter. A list of manufacturers/brands were listed. The list provided did not include an alcohol wipe to be an effective disinfecting agent for the blood glucose meter; -The guidelines for cleaning and disinfecting the meter included wiping the entire surface of the meter using the towelette at least three times vertically and three times horizontally to clean blood and other body fluids from the meter. During an interview on 3/6/20 at 5:30 P.M., the administrator and Director of Nurses said the facility's blood glucose meters should be cleaned in between residents, with the special cleaner the facility has in stock and that facility staff had been inserviced to use. An alcohol wipe is not an appropriate cleanser to use to disinfect the meters. Staff are

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) expected to clean medication vials with an alcohol wipe before inserting the needle when preparing for an injection.

F 0883

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Develop and implement policies and procedures for flu and pneumonia vaccinations.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interview and record review, facility staff failed to maintain and follow policies and procedures for immunization of residents against pneumococcal disease as required. The facility staff failed to provide and document provision of pertinent information regarding the pneumococcal vaccine including the benefits and potential side effects of the pneumococcal vaccine for six residents (Residents #1, #6, #8, #21, #77, and #88). The facility also failed to assess and vaccinate eligible residents with the pneumococcal vaccine with recommended doses of pneumococcal vaccine as indicated by the Centers for Disease Control (CDC) guidelines. The facility census was 99. Review of the US Department of Health and Human Services CDC Pneumococcal Vaccine Timing for Adults dated 11/30/15 showed the following: -Two pneumococcal vaccines were recommended for adults: 13-valent pneumococcal conjugate vaccine (PCV13, PREVNAR13) and 23-valent pneumococcal [MEDICATION NAME] vaccine (PPSV23, [MEDICATION NAME] 23); -One dose of PCV 13 was recommended for adults [AGE] years or older who had not previously received PCV13; -One dose of PPSV23 was recommended for adults [AGE] years or older, regardless of previous history of vaccination with pneumococcal vaccines. Once a dose of PPSV23 was given at age [AGE] years or older, no additional doses of PPSV23 should be administered; -For those age [AGE] years or older who had not received any pneumococcal vaccines, or those with unknown vaccination history administer one dose of PCV13. Administer one dose of PPSV23 at least one year later for most adults or at least eight weeks later for adults with immunocompromising conditions; -For those age [AGE] years or older who previously received one dose of PPSV 23 and no doses of PCV13 administer one dose of PCV13 at least one year after the dose of PPSV23 for all adults regardless of medical conditions. Review of the Center for Disease Control (CDC) website, last updated 12/6/17, showed the CDC recommendations for healthcare providers directs providers to: -There are two types of pneumococcal vaccines available in the United States: Pneumococcal conjugate vaccine (PCV13 or Prevnar13) Pneumococcal [MEDICATION NAME] vaccine (PPSV23 or [MEDICATION NAME]) - CDC recommends pneumococcal vaccination for all adults [AGE] years or older. In certain situations, other children and adults should also receive pneumococcal vaccines. Below is more information about which pneumococcal vaccines CDC recommends by age group and medical condition (where applicable). *For Adults 19 through [AGE] years: -CDC recommends pneumococcal vaccination for adults 19 through [AGE] years old who have certain medical conditions or who smoke. *For anyone with any of the conditions listed below who has not previously received the recommended pneumococcal vaccines: [DIAGNOSES REDACTED]s Cochlear implant(s) CDC recommends you: Give 1 dose of PCV13 and 1 dose of PPSV23. Administer PCV13 first, then give the PPSV23 dose at least 8 weeks later. *For anyone with any of the conditions listed below who has not previously received the recommended pneumococcal vaccines: [MEDICAL CONDITION] cell disease or other hemoglobinopathies Congenital or acquired asplenia Congenital or acquired [MEDICAL CONDITIONS] or nephroti[DIAGNOSES REDACTED] or [MEDICAL CONDITION] Hodgkin's disease Generalized malignancy Iatrogenic immunosuppression (diseases requiring treatment with immunosuppressive drugs, including long-term systemic corticosteroids and [MEDICAL CONDITION] therapy) Solid organ transplantation [DIAGNOSES REDACTED] CDC recommends you: Give 1 dose of PCV13 and 2 doses of PPSV23. Administer PCV13 first, then give the first PPSV23 dose at least 8 weeks later. Give the second dose of PPSV23 at least 5 years after the first. *For anyone who smokes and has not previously received the recommended pneumococcal vaccine CDC recommends you: Give 1 dose of PPSV23. *For anyone with any of the conditions listed below who has not previously received the recommended pneumococcal vaccine: Alcoholism Chronic [MEDICAL CONDITION] Chronic liver disease [MEDICAL CONDITION] Diabetes mellitus CDC recommends you: Give 1 dose of PPSV23. *Adults [AGE] years or Older CDC recommends pneumococcal vaccination for all adults [AGE] years or older: Give 1 dose of PCV13 to all adults [AGE] years or older who have not previously received a dose. Give 1 dose of PPSV23 to all adults [AGE] years or older at least 1 year after any prior PCV13 dose and at least 5 years after any prior PPSV23 dose. Adults who received one or two doses of PPSV23 before age 65 should receive one final dose of the vaccine at age 65 or older. Review of the facility's undated Pneumococcal Vaccine policy, showed all residents will be offered the option to receive a pneumococcal vaccination every five years unless medically contraindicated. This vaccination may be offered at any time during the year. It will be the responsibility of the DON/designee to ensure completion. Review of the policy showed it has not been updated to reflect the current CDC guidelines for the pneumococcal vaccine. Procedure: Each resident will be offered a pneumococcal vaccination at the time of admission to the facility annually thereafter, each time the vaccination is refused, unless due to a medical contraindication. 1) Each resident of his/her legal representative will receive education regarding the benefits and potential side effects of the pneumococcal immunization each time it is offered. 2) Each resident's medical record shall include documentation that education was provided to the resident or his/her legal representative. 3) Each resident or his/her legal representative will be required to return an authorization form, allowing the facility to administer the pneumococcal immunization which shall also include a signature certifying reception of educational material. 4) Each resident's medical record shall contain a physician's orders [REDACTED]. 5) The pneumococcal immunization will be provided to each resident providing written authorization at time of admission and every five years thereafter as permissible unless medically contraindicated. 6) Each resident's medical record shall contain documentation verifying that the pneumococcal immunization was administered, refused, or not given related to a medical contradiction tracking sheet and/or nurses notes. 7) If the facility is unable to obtain verification at the time of admission from the resident or his/her legal representative that a pneumococcal vaccination has been administered in the last five years, the resident will receive the immunization at the time of admission. 8) The DON/designee will ensure that the MDS Coordinator is kept informed of each resident's status regarding the pneumococcal immunization for accurate documentation on the MDS. Review of the physician order [REDACTED]. Review of Resident #1's significant change Minimum Data Set (MDS), a federally mandated assessment, dated [DATE], showed the staff documented that the resident's pneumococcal vaccination was up to date. Review of the resident's paper chart showed staff did not document pneumococcal vaccine history, provision of pneumococcal vaccine education, and pneumococcal consent/refusal form. Review showed staff did not offer the pneumonia vaccination as directed by the CDC. The Resident Immunization Record, showed no documentation showing PCV13 or PPSV23 vaccine had been given. The facility staff were unable to produce documents showing the pneumonia vaccines had been offered and refused. 2. Review of Resident #6's quarterly MDS, a federally mandated assessment, dated 12/[DATE]9, showed the staff documented that the resident refused the pneumococcal vaccination. Review of the resident's paper chart showed staff did not document pneumococcal vaccine history, provision of pneumococcal vaccine education, and pneumococcal consent/refusal form. Review showed staff did not offer the pneumonia vaccination as directed by the CDC. The Resident Immunization Record, showed documentation the [MEDICATION NAME] vaccine was refused on 11/1/17. There was no documentation showing PCV13 or PPSV23 vaccine had been offered, given, of refused since 11/1/17. The facility staff were unable to produce documents showing the pneumonia vaccines had been offered and refused. 3. Review of Resident #8's quarterly MDS, a federally mandated assessment, dated 12/5/19, showed the staff documented that the resident's pneumococcal vaccine is up to date. Review of the resident's paper chart showed staff did not document pneumococcal vaccine history, provision of pneumococcal vaccine education, and pneumococcal consent/refusal form. Review showed staff did not offer the pneumonia vaccination as directed by the CDC. The Resident Immunization Record, showed documentation the [MEDICATION NAME] vaccine was given at Mercy hospital on [DATE]. There was no documentation showing PCV13 or PPSV23 vaccine had been offered, given, of refused since 2/15/17. The facility staff were unable to produce documents showing the pneumonia vaccines had been offered and refused. 4. Review of Resident #21's quarterly MDS, a federally mandated assessment, dated 12/3/19, showed the staff documented that the resident's pneumococcal vaccine is up to date. Review of the resident's paper chart showed staff did not document pneumococcal vaccine history, provision of pneumococcal vaccine education, and pneumococcal consent/refusal form. Review showed staff did not offer the pneumonia vaccination as directed by the CDC. The Resident Immunization Record, showed documentation the [MEDICATION NAME] vaccine was given on 11/2/17. There was no documentation to show if PCV13 or PPSV23 vaccine was given or if all pneumonia vaccines had been offered, given, of refused since 11/2/17.

The facility staff were unable to produce documents showing the pneumonia vaccines had been offered and refused. 5. Review of Resident #77's admission MDS, a federally mandated assessment, dated 1/3/20, showed the staff documented that the resident's pneumococcal vaccine is up to date. Review of the resident's paper chart showed staff did not document pneumococcal vaccine history, provision of pneumococcal vaccine education, and pneumococcal consent/refusal form. Review showed staff did not offer the pneumonia vaccination as directed by the CDC. The Resident Immunization Record, showed documentation the [MEDICATION NAME] vaccine was given, per hospital record, on 9/2[DATE]8. There was no documentation to

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CREVE COEUR MANOR	**1127 TIMBER RUN DRIVE SAINT LOUIS, MO 63146**

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 0883 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) show if PCV13 or PPSV23 vaccine was given or if all pneumonia vaccines had been offered, given, of refused. The facility staff were unable to produce documents showing the pneumonia vaccines had been offered and refused. 6. Review of Resident #88's Annual MDS, dated [DATE], showed the staff documented the resident's pneumococcal vaccination was up to date. Review of the resident's chart showed an Authorization for Pneumococcal Vaccination form, dated 6/16/17, where staff documented they received permission to administer the pneumococcal vaccination from the resident's responsible party via the telephone. Review of the resident's chart showed a Resident Immunization Record where staff documented under the [MEDICATION NAME] Vaccine Administration Record that the resident received this vaccination on 12/1/17. Review showed staff did not document if the PCV13 was received. During an interview on 3/6/20 at 10:30 A.M., the Administrator said the facility tries to offer Prevnar 13 and PPSV23 and should follow the CDC recommendations. There has been a change in the Director of Nursing and the records for the pneumonia vaccines could not be located.
F 0919 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the call light bulbs illuminated in the hallway for resident rooms and resident bathrooms when the call light button was activated. This practice potentially affected all residents in the facility. The facility census was 99 residents. 1. Observations with the Maintenance supervisor on 3/06/20, showed: -At 8:56 A.M., room [ROOM NUMBER], the call light to the hallway was burnt out. -At 10:29 AM., the call light bulb on the ground level and used by residents when in activities had been disabled and was not in working condition. During an interview on 3/06/20 at 10:29 A.M., the maintenance director said he did not know about these, because he had not been told by the staff there was a problem.