STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285144	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BCP BLUE HILL, LLC	**414 NORTH WILLSON BLUE HILL, NE 68930**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Licensure Reference Number 175NAC 12-006.18B Based on observations, record reviews, and interviews the facility failed to ensure that scrapes on walls were repaired in the facility 100 and 300 hallways and in the resident room of 1 resident (Resident 4); and failed to ensure that the closet doors in the resident room for 1 resident (Resident 4) was repaired to allow the resident to open and close the doors; and that the resident window had a screen in place for 1 resident (Resident 4). The facility census was 35. Findings are: A. Observation on 8/18/20 at 8:05 AM revealed unrepaired scrapes on the wall in the facility 100 hallway. Unrepaired scrapes in the wall on the facility 300 hallway were observed. Observation on 8/19/20 at 9:06 AM revealed that the wall in the room of Resident 4 contained several areas of scraped paint and holes in the wall above the resident's dresser. On 8/20/20 at 1:12 PM during a tour of the facility with the Regional Director of Operations (RDO), Operations Support (OS), and the facility Maintenance Coordinator (MC) the RDO confirmed that there were scrapes on the walls on the 100 hallway, 300 hallway, and in the room of Resident 4 that needed to be repaired. B. Record review of the facility grievance log (a record of formal complaints) revealed that a grievance had been received by the facility on 5/26/20 from Resident 4 in regard to resident closet doors. Interview on 8/19/20 at 9:06 AM with Resident 4 revealed that the resident is unable to open or shut the closet doors in the resident's room. The resident confirmed that the resident had notified the facility that the doors did not function. Observation on 8/19/20 at 9:06 AM revealed that the closet doors in the room of Resident 4 did not open and close and that the bottom of the doors rested on the floor. On 8/20/20 at 1:12 PM during a tour of the facility with the Regional Director of Operations (RDO), Operations Support (OS), and the facility Maintenance Coordinator (MC) the RDO confirmed that the closet doors in the room of Resident 4 were not able to be opened and closed by the resident and needed to be repaired. C. Observation on 8/19/20 at 9:06 AM revealed that the outside window in the room of Resident 4 did not have a screen in place. Interview on 8/19/20 at 9:06 AM with Resident 4 revealed that the facility was aware that the screen was not in place. On 8/20/20 at 1:12 PM during a tour of the facility with the Regional Director of Operations (RDO), Operations Support (OS), and the facility Maintenance Coordinator (MC) the RDO confirmed that the outside window screen was not in place in the room of Resident 4 and that it needed to be repaired. The OS confirmed that the facility would take care of it.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175NAC 12-006.09C3 Licensure Reference Number 175NAC 12-006.09C3a Based on record reviews and interviews the facility failed to ensure the discharge summary including a recapitulation of stay (A concise summary of the resident's stay and course of treatment in the facility) was completed to include the required elements for 2 discharged residents of 2 residents reviewed (Residents 35 and 37). This had the potential to affect the successful transition of care after discharge from the facility. The facility census was 35. Findings are: A. Record review of the Admission Record for Resident 35 revealed the resident was admitted to the facility on [DATE] after having a stroke. [DIAGNOSES REDACTED]. The Admission Record revealed that the resident discharged from the facility on 6/9/2020. Record review of the physician orders for Resident 35 revealed an order dated 6/5/20 to discharge the resident to home on Tuesday 6/9/20. Record review of the facility policy titled Discharge Planning dated 9/1/18 revealed Policy Guidelines section B: The Social Service Department facilitates the Discharge Planning process which includes, without limitation: 10. Completion of the necessary sections of the interdisciplinary discharge summary/recapitulation of the resident's stay. Procedure step 5. On the day of discharge: 1. The resident/Resident Representative is given a copy of the interdisciplinary discharge summary/recapitulation of resident's stay, the post discharge plan of care, any documents that may be required, and a copy of who and how to contact the community if problems arise related to the discharge. B. Discharge Summary. Each resident has a discharge summary. The discharge summary contains necessary medical information to the receiving provider assuming responsibility for the resident's care after discharge. The discharge summary may be furnished in either hard copy or electronic format. The medical record must contain the discharge summary information and identify the recipient of the summary. The discharge summary includes without limitation: 1. Recapitulation of stay: A recapitulation of the resident's stay including diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results will be completed by the nurse and signed off by the physician. 2. A final summary of the resident's status. i. This includes the items from the resident's most recent comprehensive assessment in order to accurately describe the current clinical status of the resident. The final summary involves an interdisciplinary approach requiring Nursing, Dietary, Recreation/Lifestyle 360, Social Service, and Rehabilitation to complete the identified sections. The final summary includes the following: 1. Identification and demographic information; 2. Customary routine; 3. Cognitive patterns; 4. Communication; 5. Vision; 6. Mood and behavior patterns; 7. Psychosocial well-being; 8. Physical functioning; 9. Continence; 10. Disease [DIAGNOSES REDACTED]. Dental and nutritional status; 12. Skin Condition; 13. Activity pursuits; 14. Medications; 15. Special treatments and procedures; 16. Discharge planning. Record review of the Nursing Discharge Summary/Post Discharge Plan of Care dated 6/9/2020 for Resident 35 revealed it contained no discharge summary or recapitulation of stay in the social services sections which were left blank. There was no documentation regarding who and how to contact the community (facility) if problems arise related to the discharge. The Nursing Discharge Summary/Post Discharge Plan of Care contained no resident recapitulation of stay to include diagnoses, course of resident illness/treatment, or date of last physical exam in the Nursing sections of the form. The Nursing Discharge Summary/Post Discharge Plan of Care contained no resident recapitulation of stay to include the resident's diet order, supplements, or nutrition discharge summary/instructions which were left blank. Record review of the progress notes in the resident medical record for Resident 35 revealed the last progress note was dated 6/9/20. The note read: Ensure pressure relief mattress is functional every shift. Resident discharged home from facility. The progress notes did not contain a description of the details of the resident's discharge from the facility. Interview on 8/20/20 at 1:37 PM with the Facility Administrator (FA) confirmed the expectation for documentation of discharge for residents that discharge from the facility is to include the completion of the facility Discharge Summary/Post Discharge Plan of Care evaluation and for the Discharge Summary/Post Discharge Plan of Care to be completed fully with all required information. The FA confirmed that a progress note regarding the resident status and resident discharge should be completed. B. Record review of the Admission Record for Resident 37 revealed the resident was admitted to the facility on [DATE]. [DIAGNOSES REDACTED]. The Admission Record revealed that the

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 0661 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident discharged from the facility on 6/9/2020. Record review of the resident medical record for Resident 37 revealed a transfer order dated 6/9/20 to make arrangements to transfer the resident for evaluation and treatment for 1 day for behavioral health services that was signed by the resident's physician. Record review of the facility policy titled Discharge Planning dated 9/1/18 revealed Policy Guidelines section B: The Social Service Department facilitates the Discharge Planning process which includes, without limitation: 10. Completion of the necessary sections of the interdisciplinary discharge summary/recapitulation of the resident's stay. Procedure step 5. On the day of discharge: 1. The resident/Resident Representative is given a copy of the interdisciplinary discharge summary/recapitulation of resident's stay, the post discharge plan of care, any documents that may be required, and a copy of who and how to contact the community if problems arise related to the discharge. 2. The Social Worker faxes the interdisciplinary discharge summary/recapitulation of resident's stay and post discharge plan of care to the appropriate service agencies. 3. Nursing faxes the interdisciplinary discharge summary/recapitulation of resident's stay and post discharge plan of care to the accepting physician. B. Discharge Summary. Each resident has a discharge summary. The discharge summary contains necessary medical information to the receiving provider assuming responsibility for the resident's care after discharge. The discharge summary may be furnished in either hard copy or electronic format. The medical record must contain the discharge summary information and identify the recipient of the summary. The discharge summary includes without limitation: 1. Recapitulation of stay: A recapitulation of the resident's stay including diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results will be completed by the nurse and signed off by the physician. 2. A final summary of the resident's status. i. This includes the items from the resident's most recent comprehensive assessment in order to accurately describe the current clinical status of the resident. The final summary involves an interdisciplinary approach requiring Nursing, Dietary, Recreation/Lifestyle 360, Social Service, and Rehabilitation to complete the identified sections. The final summary includes the following: 1. Identification and demographic information; 2. Customary routine; 3. Cognitive patterns; 4. Communication; 5. Vision; 6. Mood and behavior patterns; 7. Psychosocial well-being; 8. Physical functioning; 9. Continence; 10. Disease [DIAGNOSES REDACTED]. Dental and nutritional status; 12. Skin Condition; 13. Activity pursuits; 14. Medications; 15. Special treatments and procedures; 16. Discharge planning. Record review of the medical record for Resident 37 revealed a Discharge Summary/Post Discharge Plan of Care and recapitulation of the resident's stay in the facility was not completed. Record review of the medical record for Resident 37 revealed a Transfer Form dated 6/9/20. The transfer form did not contain information regarding the resident's primary diagnosis, decision making capacity, ambulatory status, mental status/cognitive function, name of who to call at the facility to get questions answered, the name of the resident's physician, diet and nutritional status, and behavioral issues. The form was not signed and contained no documentation of who completed the form. Record review of the progress notes in the resident medical record for Resident 37 revealed a progress note dated 6/9/20 at 9:55 AM. The note documented that the Facility Administrator and Social Services went to the resident's room at 8:30 AM and notified the resident that a hospital had agreed to see the resident to see if they can help the resident. The resident allowed the aides to get the resident up in a wheelchair and the resident was taken to the facility van. The resident left with a pair of shorts, a shirt, sunglasses, cell phone, and charger. Record review of the progress notes in the resident medical record for Resident 37 revealed a progress note dated 6/9/20 at 9:58 AM. The note documented that the resident refused to sign a bed hold (a form reserving a resident's bed while the resident is absent from the facility). Record review of the progress notes in the resident medical record for Resident 37 revealed that the last progress note was dated 6/9/20 at 9:07 PM. The note read: Resident discharged from facility. Interview on 8/20/20 at 1:37 PM with the Facility Administrator (FA) confirmed that the expectation for documentation of discharge for residents that discharge from the facility is to include the completion of the facility Discharge Summary/Post Discharge Plan of Care evaluation and for the Discharge Summary/Post Discharge Plan of Care to be completed fully with all required information.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC ,[DATE].09 Based on interviews and record reviews; the facility failed to assess and notify the provider of a potential change in condition for 2 of 2 sampled residents (Resident 19 and Resident 35). The facility identified a census of 35 at the time of survey. Findings are: Review of Resident 19's Admission Record revealed an admission date of [DATE]. Review of Resident 19's Progress Notes revealed on [DATE] at 12:02 AM it was documented by LPN-B a CNA (Certified Nurse Aide) reported Resident 19's right foot appeared swollen and dusky with no pedal pulse palpated. There was no documentation the condition of Resident 19's foot was followed up on or reported to the medical provider. Review of Resident 19's Progress Notes revealed LPN-B (Licensed Practical Nurse) documented they reported to RN-D (Registered Nurse) on [DATE] at 6:07 PM Resident 19's right foot to ankle had duskiness and was cold with no pedal pulse and the medical provider would be notified the next day. There was no documentation the condition of Resident 19's foot was followed up on or reported to the medical provider. On [DATE] at 4:05 PM, the FA (Facility Administrator) was inquired about documentation that the condition of Resident 19's foot was assessed and reported to the medical provider. The FA said they would look for it. Review of Resident 19's Progress notes dated [DATE] at 4:20 PM revealed the following: Health Status Note Note Text: Right foot somewhat darker than the left and cooler than the left. Can palpate faint pulse but it is also faint on right side. Good capillary refill, negative Homan's sign (a procedure used to check for a blood clot). Denies pain. Notified the medical provider and orders received to give ASA (Aspirin) 325 mg po (by mouth) x 1 and notify medical provider if it worsens. States medical provider will see Resident 19 in house tomorrow. [DATE] 23:46 (11:46 PM) Health Status Note Note Text: Full assessment completed. Resident continues to be confused. Resident is alert and is confused to place situation and time. Resident pedal pulses are palpable but weak bilaterally both feet are cool to touch. Resident states (gender) sensation is normal. (Gender) feet have 1+ [MEDICAL CONDITION] bilaterally. [DATE] 22:13 (10:13 PM) Health Status Note Note Text: Order received earlier to give 325 mg of ASA. At that time this nurse had her BP medication in the cup to give and was going to give that and then go get ASA. Resident was very confused (this was at approximately. 1700 (5:00 PM) and would not take any medications. Stated (gender) wouldn't take any other medications. Supper was served at 1800 (6:00 PM). Attempted to give HS (bedtime) medications and one time dose of ASA and resident continues to refuse any medications at all. Interview with RNC (Registered Nurse Consultant) on [DATE] at 8:40 AM revealed the facility did not have a policy for change in condition including assessment and notification of the medical provider. The RNC confirmed there was no documentation the facility staff assessed Resident 19's foot and notified the medical provider prior to being alerted to the issue by the surveyor. RNC revealed the expectation was that an assessment should have been completed and the provider notified right away. Interview with Resident 19's medical provider on [DATE] at 11:30 AM confirmed the facility staff notified them about Resident 19's foot on [DATE] and the the fax notification was at the clinic that morning when they arrived. The medical provider revealed Resident 19 had a previous fracture and that the foot was not a new problem. The medical provider revealed there had been a change in Resident 19's condition as Resident 19 was brewing a UTI and the family wanted conservative management of their medical condition. Reviewed of Resident 19's Progress Notes revealed there was no other documentation about Resident 19's foot. Resident 19 had been a resident in the facility since [DATE]. Review of Resident 19's Care Plan dated [DATE] revealed no documentation the cold, dusky, pulseless foot was a chronic condition. Review of Resident 19's documents revealed there was no documentation the provider was notified about Resident 19's foot prior to being alerted to the documentation of the condition by the surveyor. Review of Resident 19's Care Plan dated ,[DATE] revealed no documentation of the foot anomaly being a chronic condition and that the family wanted conservative management of their medical condition. Review of Resident 19's Preferred Intensity of Medical Care and Treatment form dated [DATE] revealed no documentation of do not treat. This was an option on the form to select do not treat and it was not checked. DNR (Do Not Resuscitate) was the only item checked. Interview with RNC on [DATE] at 2:05 PM confirmed there was no documentation of the follow up assessment and notification of the medical provider regarding Resident 19's foot. B. Review of Resident 35's Admission Record revealed an admission date of [DATE]. Review of Resident 35's Progress Notes revealed the following: [DATE] 08:00 AM Health Status Note Note Text: Resident had a low grade temp this am. Denies not feeling well. LS (Lung Sounds) clear no cough noted. Did note to have an episode of SOB (Shortness of Breath) after ambulating from BR (bathroom) to bed, after sitting on the bed SOB subsided. [DATE] 09:30 AM Health Status Note Note Text: Resident sitting on the bed states to this nurse that the resident doesn't feel good. Continues to have a

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) low grade temp. LS clear. Denies having any cough or sore throat. Assisted resident with laying down to rest. [DATE] 01:46 AM Health Status Note Note Text: Resident up to nurses station x's (times) two, this time c/o (complains of) of SOB, and not feeling well assisted back to bed, PRN (as needed) Tylenol given, T. 97.6 T, Respirations. 18 no signs/symptoms of respiratory distress noted. no cough, lung fields CTA (clear to auscultation), PRN Nebulizer TX (breathing treatment). given with relief voiced. Color is pale skin cool and dry. [DATE] 07:30 AM Health Status Note Note Text: T 99.1 Resident is pale. Denies any ill feelings. Alert. Lungs clear. Respirations even and unlabored. No SOB noted. [DATE] 12:23 PM Health Status Note Note Text: T 99.1 sent fax to update Dr. on temp and asking to check UA. [DATE] 6:15 PM Health Status Note Note Text: Resident had been moved to room [ROOM NUMBER] at approximately 1715 (5:15 PM) due to running a fever (due to shared bathroom and current CDC recommendations in light of current COVID-19 pandemic). Therapy reported that they had spent quite a bit of time with (resident) in (resident) room as (gender) was upset about the move to other room. At this time (1815 (6:15 PM) I went to (gender) room and (gender) was sitting on side of bed. (Resident) was confused but not yelling or screaming. I reassured (gender) that supper was coming down the hall and (gender) stay in the new room would be as short as we could make it. Resident visited with me, no shortness of breath noted. (Resident) is holding (gender) call light. Skin is pink. (Resident) does not complain of any pain. As I left the room, CNA is coming down the hall with supper. The CNA did have to stop and go get a bedside table for (gender) to eat on. Resident is calm when I left room. [DATE] 20:31 Health Status Note Note Text: resident had fever of 101.6, lung sounds were CTA, stated no pain, no abdomen pain, no pain with urination, physician had been originally notified regarding fever during day shift, had not received any orders back as of yet, resident made aware (gender) is to stay in (gender) room due to fever, resident understanding as resident shares a restroom, had to move resident to a private isolation room, resident moved approximately 1700, initially upset regarding the move, stating (gender) did not know this room. resident became less upset regarding the move as several staff members were in and out comforting resident about the move. resident declined dinner approximately 1830. Med aid went to residents room approximately 2010, turned on call light, this nurse entered room to find resident lying on (gender) right side, not breathing, assessed for heart beat while med aid went to check code status, resident had no heart beat and is a DNR. updated administrator, DON, POA (name), on-call physician and funeral home. Dr gave verbal order to release the body to the funeral home. Review of Resident 35's temperature checks revealed the following: [DATE] 17:00 (5 PM) 100.0 F Temporal Artery [DATE] 16:30 (4:30 PM) 100.8 F Oral [DATE] 16:16 101.6 F Temporal Artery [DATE] 10:24 99.1 F Temporal Artery [DATE] 16:29 98.7 F Temporal Artery [DATE] 09:32 99.6 F Temporal Artery [DATE] 08:01 98.8 F Oral [DATE] 08:00 99.4 F Temporal Artery Review of the Covid-19 facility spreadsheet revealed there was no testing date but it read Resident 35 was negative and they marked Resident 35's death on the spreadsheet as NOT COVID. There was no documentation of a Covid 19 test date being completed. Interview with the FA on [DATE] at 2:40 PM Revealed Resident 35 spiked a temperature late in the afternoon and Resident 35 was dead by the next morning. The FA revealed the typical for Resident 35 was to be septic for UTI (Urinary Tract Infection). The FA revealed Resident 35's only symptom was the fever. The FA revealed the facility staff moved Resident 35 out to another room as a precaution as Resident 35 was sharing a bathroom with another resident. The FA revealed Resident 35 actually died before they could get a Covid-19 test and the facility had planned on getting one but Resident 36 didn't live long enough. The FA revealed Resident 35 had a really bad heart and needed a new heart valve but the family deferred due to Resident 35's condition. The FA revealed the medical provider felt that Resident 35 died as a result [MEDICAL CONDITION] from a UTI and a weak heart. Documentation of the provider rationale for Resident 35's death was requested from the FA. Review of Resident 35's UA (urinalysis) report dated [DATE] revealed the UA was abnormal and the culture came back as proteus mirabilis (a type of organism that causes urinary tract infections). On [DATE] at 3:45 PM documentation was requested from the FA and RNC regarding the medical provider indications for Resident 35's cause of death. RNC revealed they had a call out to the clinic to obtain the documentation. Review of Resident 35's Evaluations revealed Covid 19 daily surveillance was documented twice a day. Resident 35 did not have a fever documented until [DATE] at 4:16 PM. Review of Resident 35's Progress Notes revealed no documentation the medical provider was notified when Resident 35's temperature was 101.6 F. Interview with RNC on [DATE] at 8:56 AM revealed they believed the facility staff notified the medical provider when Resident 35's temperature climbed to 101.6 F. RNC revealed they called the clinic requesting the log of the calls they made to the provider. Interview with the FA on [DATE] at 1:11 PM revealed they believed the facility staff notified the medical provider when Resident 35's temperature was 101.6 F and they would look for the documentation. The FA confirmed the staff did notify the provider when Resident 35's temperature was 99.1 F. On [DATE] at 1:58 PM The FA did not provide the documentation the provider was notified about Resident 35's temperature of 101.6. Interview with RNC on [DATE] at 2:05 PM confirmed the supportive documentation of the conditions for Resident 19 and Resident 35 should have been documented in the medical record.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D Based on interviews and record reviews; the facility staff failed to notify the provider when a medication was ordered that Resident 9 had a documented allergy to and a potential drug interaction. This affected 1 of 5 residents reviewed. The facility identified a census of 35 at the time of survey. Findings are: Review of Resident 9's Admission Record revealed an admission date of [DATE]. Review of Resident 9's Order Summary Report for 8/20/2020 revealed an allergy to NSAIDs (Non-Steroidal Anti-[MEDICAL CONDITION] Drugs). Resident 9 had an order for [REDACTED]. Review of Resident 9's MAR (Medication Administration Record) for August 2020 revealed documentation the [MEDICATION NAME] Sodium was administered to Resident 9 as ordered. Review of Resident 9's Progress Notes revealed the following: 7/25/2020 13:31 (1:31 PM) Order Note Note Text: The system has identified a possible drug allergy for the following order: [MEDICATION NAME] Sodium Tablet 220 MG Give 1 tablet by mouth two times a day for inflammation. 7/25/2020 13:31 Order Note Note Text: The order you have entered [MEDICATION NAME] Sodium Tablet 220 MG Give 1 tablet by mouth two times a day for inflammation Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction The system has identified a possible drug interaction with the following orders: Eliquis (blood thinner) Tablet 2.5 MG Give 1 tablet by mouth two times a day for [MEDICAL CONDITION] Severity: Severe Interaction: Use of Eliquis Tablet 2.5 MG (milligrams) with [MEDICATION NAME] Sodium Tablet 220 MG may increase the risk of bleeding. [MEDICATION NAME] (antidepressant) HCl Tablet 25 MG Give 0.5 tablet by mouth one time a day for depression Severity: Severe Interaction: Toxic effects may be increased with concurrent administration of [MEDICATION NAME] Sodium Tablet 220 MG and [MEDICATION NAME] HCl Tablet 25 MG. The risk of upper [MEDICAL CONDITION] may be increased. Patients taking both drugs concurrently should be educated about the signs and symptoms of GI bleeding. Nursing N There was no documentation in Resident 9's Progress Notes the medical provider was contacted to follow up on the [MEDICATION NAME] that was ordered with Resident 9 having an allergy to it or a potential drug interaction with the other medications Resident 9 was receiving. On 8/20/20 at 10:07 AM the FA (Facility Administrator) was inquired for documentation the facility staff followed up with the medical provider about the potential allergy to [MEDICATION NAME] the system had alerted them to. This was not received. Interview with RNC (Registered Nurse Consultant) on 8/20/20 at 12:44 PM confirmed there was no documentation the medical provider was notified about the potential allergy to [MEDICATION NAME] the system had alert them to. RNC revealed the expectation was the medical provider would be notified if the allergy alert came up.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.10D Based on observations, interviews, and record reviews; the facility failed to maintain a medication error rate below 5%. The facility had 4 errors out of 28 opportunities with a medication error rate of 14.29% which affected 4 of 9 resident observed for medication administration (Residents 4, 27, 2, and 12). The facility identified a census of 35 at the time of survey. Findings are: A. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:01 PM revealed they prepared an insulin pen for insulin injection for Resident 4. LPN-A dialed the dose of insulin without priming the insulin pen then administered 13 units of [MEDICATION NAME] (regular) insulin to Resident 4 into their right arm. B. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:14 PM revealed LPN-A dialed a 5 unit dose on a [MEDICATION NAME]pen for Resident 27 then administered the insulin to Resident 27. LPN-A did not prime the insulin pen prior to dialing the dose before administering the insulin to Resident 27. C. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:34 PM revealed LPN-A dialed a 28 unit dose on a [MEDICATION NAME]pen for Resident 2. LPN-A administered the insulin to Resident 2. LPN-A did not prime the insulin pen prior to dialing the dose before administering the insulin to Resident 2. D. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:39 PM revealed LPN-A dialed a 7 unit dose on a [MEDICATION NAME]pen for Resident 12. LPN-A administered the insulin to Resident

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) 12. LPN-A did not prime the insulin pen prior to dialing the dose before administering the insulin to Resident 12. Interview with the FA (Facility Administrator) on 8/19/20 at 2:36 PM revealed LPN-A did not prime the insulin pen and should have. Interview with RNC (Registered Nurse Consultant) at this time also revealed they had asked LPN-A to walk them through the steps of administering the insulin to the residents with the insulin pen and LPN-A omitted the step to prime the insulin pen. RNC concurred with the FA that LPN-A should have primed the insulin pens prior to administering the insulin. Review of the package insert received from RNC revealed the following: Priming your FlexTouch Pen: Step 7: turn the dose selector to select 2 units. Step 8: Hold the Pen with the needle point up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The '0 must line up with the dose pointer. A drop of insulin should be seen at the needle. If you do not see a drop of insulin repeat steps 7 to 9. If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9. Review of the How To Use [MEDICATION NAME] manufacturer's directions for use revealed the following: 1. Check your pen Check the name and colored label of your pen to make sure that it contains the correct type of insulin. Pull off the pen cap. 2. Attach a new needle Remove the protective tab from a new needle. Screw the needle straight and tightly onto your pen. Pull off both needle caps. Keep the big outer needle cap. 3. Check the insulin flow Turn the dose selector to select 2 units. Press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. 4. Select your dose Check that the dose selector is set at 0. Turn the dose selector to select the number of units you need to inject. You can turn the dose selector up or down to adjust the dose. 5. Inject your dose Insert the needle into your skin. Press the push-button all the way in until 0 lines up with the pointer. The needle must remain under the skin for at least 6 seconds. This will ensure that the full dose has been injected. 6. Remove the needle Lead the needle into the big outer needle cap. When the needle is covered carefully push the big outer needle cap completely on. Unscrew the needle and dispose of it carefully. Then put the pen cap back on.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.10D Based on observations, interviews, and record reviews; the facility failed to ensure residents received the amount of insulin ordered by failing to prime the insulin pen prior to insulin administration which resulted in significant medication errors for 4 of 4 residents observed (Residents 4, 27, 2, and 12). The facility identified a census of 35 at the time of survey. Findings are: A. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:01 PM revealed they prepared an insulin pen for insulin injection for Resident 4. LPN-A dialed the dose of insulin without priming the insulin pen then administered 13 units of [MEDICATION NAME] (regular) insulin to Resident 4 into their right arm. B. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:14 PM revealed LPN-A dialed a 5 unit dose on a [MEDICATION NAME]pen for Resident 27 then administered the insulin to Resident 27. LPN-A did not prime the insulin pen prior to dialing the dose before administering the insulin to Resident 27. C. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:34 PM revealed LPN-A dialed a 28 unit dose on a [MEDICATION NAME]pen for Resident 2. LPN-A administered the insulin to Resident 2. LPN-A did not prime the insulin pen prior to dialing the dose before administering the insulin to Resident 2. D. Observation of LPN-A (Licensed Practical Nurse) on 08/18/20 at 12:39 PM revealed LPN-A dialed a 7 unit dose on a [MEDICATION NAME]pen for Resident 12. LPN-A administered the insulin to Resident 12. LPN-A did not prime the insulin pen prior to dialing the dose before administering the insulin to Resident 12. Interview with the FA (Facility Administrator) on 8/19/20 at 2:36 PM revealed LPN-A did not prime the insulin pen and should have. Interview with RNC (Registered Nurse Consultant) revealed at this time also revealed they had asked LPN-A to walk them through the steps of administering the insulin to the residents with the insulin pen and LPN-A omitted the step to prime the insulin pen. RNC concurred with the FA that LPN-A should have primed the insulin pens prior to administering the insulin. Review of the package insert received from RNC the following: Priming your FlexTouch Pen: Step 7: turn the dose selector to select 2 units. Step 8: Hold the Pen with the needle point up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the Pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0. The '0 must line up with the dose pointer. A drop of insulin should be seen at the needle. If you do not see a drop of insulin repeat steps 7 to 9. If you still do not see a drop of insulin, change the needle and repeat steps 7 to 9. Review of the How To Use [MEDICATION NAME] manufacturer's directions for use revealed the following: 1. Check your pen Check the name and colored label of your pen to make sure that it contains the correct type of insulin. Pull off the pen cap. 2. Attach a new needle Remove the protective tab from a new needle. Screw the needle straight and tightly onto your pen. Pull off both needle caps. Keep the big outer needle cap. 3. Check the insulin flow Turn the dose selector to select 2 units. Press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. 4. Select your dose Check that the dose selector is set at 0. Turn the dose selector to select the number of units you need to inject. You can turn the dose selector up or down to adjust the dose. 5. Inject your dose Insert the needle into your skin. Press the push-button all the way in until 0 lines up with the pointer. The needle must remain under the skin for at least 6 seconds. This will ensure that the full dose has been injected. 6. Remove the needle Lead the needle into the big outer needle cap. When the needle is covered carefully push the big outer needle cap completely on. Unscrew the needle and dispose of it carefully. Then put the pen cap back on.
F 0923 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough outside ventilation via a window or mechanical ventilation, or both.** Licensure Reference Number 175NAC 12-007.04D Based on observation and interview the facility failed to ensure the vents in resident bathrooms were functional for 5 of 5 residents reviewed (Residents 14, 7, 29, 30, and 18). This had the potential for the buildup of odors and a non-homelike environment for residents. The facility census was 35. Findings are: Observation on 8/18/20 at 8:05 AM revealed that the bathroom vents did not function in the rooms of Residents 14, 7, 29, 30, and 18 during testing. On 8/20/20 at 1:12 PM during a tour of the facility with the Regional Director of Operations (RDO), Operations Support (OS), and the facility Maintenance Coordinator (MC) the RDO confirmed that the vents in the resident bathrooms were not functioning and needed to be repaired.