STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676200	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN AGE NURSING HOME	**2613 34TH ST LUBBOCK, TX 79410**

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, the facility failed to ensure that all residents had the right to formulate an advance directive for 9 of 18 residents (Resident #1, #2, #4, #6, #15, #16, #17, #18, and #19) reviewed for advance directives. Residents #1, #2, #4, #6, #15, #16, #17, #18, and #19 had DNRs that were not valid because they were not filled out properly and in their entirety. The facility's failure to ensure accuracy of resident medical records for advance directives such as a DNR (Do Not Resuscitate) Order, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care, could place residents at risk for not receiving healthcare according to their or their legal representatives wishes. Findings include: Resident #1 Record review of Resident #1's face sheet revealed an [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The section of the face sheet titled Advance Directives indicated that the resident had a DNR. Record review of Resident #1's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 13 out of 15, indicating no cognitive impairment. Section G of the MDS indicated that she required limited assistance with dressing and personal hygiene, and extensive assistance with toilet use. Record review of Resident #1's Physician Order Report revealed an order with a start date of 09/25/2019 that read Do Not Resuscitate. Record review of the Out-Of-Hospital Do-Not-Resuscitate Order on Resident #1's chart revealed that the document did not contain the printed name of the legal guardian, agent or proxy that signed the document in section B. Additionally, the section of the document intended for witnesses (or notary) was left completely blank. During an interview on 03/11/2020 at 2:24 PM, DON reviewed the DNR of Resident #1 and reported that it was not a legal document because it was not signed by witnesses in all the required spots. Resident #2 Record review of Resident #2's clinical records revealed a [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 05 out of 15, indicating severe cognitive impairment. Section G of the MDS indicated that she required supervision with dressing, toilet use, and personal hygiene. Record review of Resident #2's DNR on her chart revealed that the section of the document intended for witnesses to (or a notary) to sign it was left blank. Resident #4 Record review of Resident #4's face sheet revealed a [AGE] year-old female with a current admission of 09/27/2011 and [DIAGNOSES REDACTED]. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMs score of 11 out of 15 indicating moderate cognitive impairment. The MDS revealed that she is requires extensive assistance with bed mobility, dressing, transfers, and toilet use; and limited assistance with personal hygiene. Record review of Resident #4's Physician Order Report, dated with active orders as of 09/25/2019 revealed the following order: Do Not Resuscitate. Special instructions: DNR Record review of Resident #4's clinical record revealed a DNR consent form signed on 02/13/2019 by Resident #4. Two witness signatures are missing from form. Resident #6 Record review of Resident #6's clinical records revealed a [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's annual MDS dated [DATE] revealed that the resident had a BIMS score of 05 out of 15, indicating severe cognitive impairment. Section G of the MDS indicated that she was totally dependent on staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. Record review of Resident #6's DNR on her chart revealed that the Physician's Statement section of the document was left blank. Resident #15 Record review of Resident #15's face sheet revealed a [AGE] year-old female with a current admission date of [DATE]. [DIAGNOSES REDACTED]. Record review of Resident #15's quarterly MDS dated [DATE] reveals a BIMs score of 8 out of 15 indicating moderate cognitive impairment. The MDS revealed that she is totally dependent on staff for bed mobility, transfers, dressing, toilet use and personal hygiene. Record review of Resident #15's Physician Order Report, dated with active orders as of 09/25/2019 revealed the following order: Do Not Resuscitate. Special instructions: DNR Record review of Resident #15's clinical record revealed a DNR consent form signed on 02/09/2019 by POA. Two witness signatures are missing from form. Resident #16 Record review of Resident #16's clinical records revealed a [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's annual MDS dated [DATE] revealed that the resident had a BIMS score of 09 out of 15, indicating moderate cognitive impairment. Section G of the MDS indicated that she was totally dependent on staff for toilet use, and required limited assistance with personal hygiene, dressing, and transfers. Record review of Resident #16's DNR on her chart revealed that the section of the document intended for witnesses (or a notary) to fill out had been left blank. Resident #17 Record review of Resident #17's face sheet revealed a [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The section of the face sheet titled Advance Directives indicated that the resident had a DNR. Record review of Resident #17's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 05 out of 15, indicating severe cognitive impairment. Section G of the MDS indicated that she required supervision with dressing and personal hygiene. Record review of Resident #17's Physician Order Report revealed that there was no physician order in the document for the resident to be a DNR. Record review of the Out-Of-Hospital Do-Not-Resuscitate Order on Resident #17's chart revealed that the document did not contain the printed name of the physician, physician license number, or date in the physician's statement section. The signature in the physician's statement section was not legible enough to determine the name of the person who signed the document. Additionally, the section of the document intended to be filled out by witnesses (or a notary) was left blank. The bottom section of the document intended to contain duplicate signatures was also not signed by any witnesses. During an interview on 03/11/2020 at 2:24 PM, DON reviewed the DNR of Resident #17 and reported that it was not a legal document. She confirmed that the physician's information was missing, and that it had not been signed by any witnesses. Resident #18 Record review of Resident #18's clinical records revealed an [AGE] year-old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #18's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 02 out of 15, indicating severe cognitive impairment. Section G of the MDS indicated that he was totally dependent on staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. Record review of Resident #6's DNR on her chart revealed that the section of the document intended to be filled out by witnesses (or a notary) was left blank. Resident #19 Record review of Resident #19's face sheet revealed a [AGE] year-old female with a current admission date of [DATE]. [DIAGNOSES REDACTED]., [MEDICAL CONDITION], anxiety disorder, and major [MEDICAL CONDITION]. Record review of Resident #19's quarterly MDS dated [DATE] reveals a BIMs score of 2 out of 15 indicating severe cognitive impairment. The MDS revealed that she required extensive

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) assistance from staff with dressing; supervision with toilet use; and limited assistance for personal hygiene. Record review of Resident #19's Physician Order Report, dated with active orders as of 09/24/2019 revealed the following order: Do Not Resuscitate. Special instructions: DNR Record review of Resident #19's clinical record revealed a DNR consent form signed on 02/12/2019 by POA. Two witness signatures are missing from form. During an interview with DON on 03/11/2020 at 2:18 PM regarding DNRs, she stated that the witnesses only signed the bottom of the forms because she thought that was all they needed to sign. Record review of facility provided policy titled Advance Directive Policy and Procedure, not dated, reflected in part: Policy The resident has the right and the facility will assist the resident to formulate an advance directive at their option. Record review of document by the Texas Department of State Health Services titled Frequently Asked Questions for DNR, retrieved from https://www.dshs.texas.gov/emstraumasystems/dnr.shtm, revealed the following: What happens if the form is not filled out correctly or EMS has doubts about any of the information? Health professionals can refuse to honor a DNR if they think: The form is not signed twice by all who need to sign it or is filled out incorrectly. Filling out the Out-of-Hospital Do-Not-Resuscitate Form Physician's Statement The patient's attending physician must sign and date the form, print or type his/her name and give his/her license number.
F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess residents for risk of entrapment from bed rails, review the risks and benefits of bed rails with residents or resident representatives, and obtain informed consent prior to installation of bed rails for 9 of 18 residents (Resident #1, #4, #6, #7, #9, #13, #15, #16, and #17) reviewed for bed rails. The facility failed to inform residents, or their representatives, of the risks and benefits of bed rails, and obtain informed consent for the use of bed rails for Residents #1, #4, #6, #7, #9, #13, #15,#16 and #17. This deficient practice could place residents at risk for unintended entrapment or restraint; and injuries such as deformities, contusions, abrasion, bruises, lacerations, fractures, and death from suffocation. Findings include: Resident #1 Record review of Resident #1's face sheet revealed an [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 13 out of 15, indicating no cognitive impairment. Section G of the MDS indicated that she required limited assistance with dressing and personal hygiene, and extensive assistance with toilet use. During an observation on 03/10/2020 at 10:32 AM, Resident #1 was sitting in a wheelchair in her room. There was a bedrail attached to one side of her bed. During an observation and interview on 03/12/2020 at 9:57 AM, Resident #1 was sitting in a wheelchair in her room. There was a bedrail attached to one side of her bed; the other side of the bed was against a wall. Resident #1 indicated the rail and stated, I use that to get in and out of bed. Resident #1 reported that the bedrail has been on her bed since she arrived at the facility. Record review of Resident #1's clinical records revealed no evidence that an entrapment risk assessment had been completed. Resident #4 Record review of Resident #4's face sheet revealed a [AGE] year-old female with a current admission of 09/27/2011 and [DIAGNOSES REDACTED]. Record review of Resident #4's quarterly MDS dated [DATE] revealed a BIMs score of 11 out of 15 indicating moderate cognitive impairment. The MDS revealed that she is requires extensive assistance with bed mobility, dressing, transfers, and toilet use; and limited assistance with personal hygiene. During an observation on 03/11/2020 at 1:05 PM, Resident #4 lying in bed after peri-care. Full side rail noted to one side of bed, the bed was pushed against the wall on the other side. Record review of Resident #4's clinical record revealed no bed rail or entrapment risk assessment form seen in chart. Resident #6 Record review of Resident #6's clinical records revealed a [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #6's annual MDS dated [DATE] revealed that the resident had a BIMS score of 05 out of 15, indicating severe cognitive impairment. Section G of the MDS indicated that she was totally dependent on staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. During an observation on 03/10/2020 at 10:30 AM, Resident #6's bed had two bedrails attached to it, one on each side of the bed. Record review of Resident #6's clinical records revealed no evidence that an entrapment risk assessment had been completed. Resident #7 Record review of Resident #7's clinical records revealed a [AGE] year-old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #7's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 02 out of 15, indicating severe cognitive impairment. Section G of the MDS indicated that he was totally dependent on staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. During an observation 03/10/2020 at 10:32 AM, Resident #7's bed had two bed rails attached to it. Record review of Resident #1's clinical records revealed no evidence that an entrapment risk assessment had been completed. Resident #9 Record review of Resident #9's clinical records revealed a [AGE] year-old male that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #9's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 11 out of 15, indicating moderate cognitive impairment. Section G of the MDS indicated that he required supervision with dressing and personal hygiene. During an observation on 03/10/2020 at 10:17 AM, Resident #9 was ambulatory in his room. His bed had a bed rail on one side and the other side was against a wall. Record review of Resident #9's clinical records revealed no evidence of informed consent for the bed rail, and no evidence that an entrapment risk assessment had been completed. Resident #13 Record review of Resident #13's face sheet revealed a [AGE] year-old female with a current admission date of [DATE]. [DIAGNOSES REDACTED]. Record review of Resident #13s quarterly MDS dated [DATE] reveals a BIMs score of 6 out of 15 indicating severe cognitive impairment. The MDS revealed that she is totally dependent on staff for bed mobility, transfers, dressing, toilet use and personal hygiene. During an observation on 03/11/20 at 09:15 AM, full bed rails were on one side of the bed, the bed pushed against the wall on the other side. Record review of Resident #13's clinical records revealed no bed rail or entrapment risk assessment form seen in chart. Resident #15 Record review of Resident #15's face sheet revealed a [AGE] year-old female with a current admission date of [DATE]. [DIAGNOSES REDACTED]. Record review of Resident #15's quarterly MDS dated [DATE] reveals a BIMs score of 8 out of 15 indicating moderate cognitive impairment. The MDS revealed that she is totally dependent on staff for bed mobility, transfers, dressing, toilet use and personal hygiene. During an observation on 03/11/2020 at 08:41 AM, there were side rails on the upper and lower part of Resident #15's bed. Record review of Resident #15's clinical record revealed no bed rail or entrapment risk assessment form seen in chart. Resident #16 Record review of Resident #16's clinical records revealed a [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #16's annual MDS dated [DATE] revealed that the resident had a BIMS score of 09 out of 15, indicating moderate cognitive impairment. Section G of the MDS indicated that she was totally dependent on staff for toilet use, and required limited assistance with personal hygiene, dressing, and transfers. During an observation on 03/10/2020 at 10:40 AM, Resident #16's bed had two bed rails attached to it. Record review of Resident #16's clinical records revealed no evidence that an entrapment risk assessment had been completed. Resident #17 Record review of Resident #17's face sheet revealed a [AGE] year-old female that was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #17's quarterly MDS dated [DATE] revealed that the resident had a BIMS score of 05 out of 15, indicating severe cognitive impairment. Section G of the MDS indicated that she required supervision with dressing and personal hygiene. During an observation on 03/10/2020 at 10:28 AM, Resident #17 was ambulatory in her room. There were two bedrails attached to her bed, one on each side. Record review of Resident #9's clinical records revealed no evidence of informed consent for the bed rail, and no evidence that an entrapment risk assessment had been completed. During an interview on 03/11/2020 at 10:50 AM, DON reported that the facility did not obtain informed consent for the use of bed rails for Resident #9 or Resident #17. DON reported that they do not acquire informed consent for the use of bedrails for residents that do not use their bed rails because they can transfer themselves independently. During

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) an interview with DON on 03/12/2020 at 09:31 AM, regarding bed rail entrapment risk assessments, DON stated she checked the charts they were not in there. DON stated they should be in the charts and she is not sure what happened to them. Record review of facility provided policy titled Bed Rail Policy, dated 2017, reflected in part: Procedure 1. Resident Assessment c. Assess the resident to identify appropriate alternative prior to installing bed rails. d. Assess the resident for risk of entrapment from bed rails prior to installation. e. Bed rails will not be used when a resident cannot raise and lower them easily, thereby meeting the definition of a restraint. f. The facility will document ongoing need for the use of a bed rail. h. Obtain informed consent.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure drugs and biologicals were stored in locked compartments and under proper temperature controls for 1 out of 1 medication room. - The temperature log for the medication refrigerator in the medication room was left blank on several dates, indicating that the facility failed to monitor for and ensure that medications were under appropriate temperature controls on those dates. - The medication room was left unlocked and unattended by staff. The facility's failure to ensure drugs and biologicals were stored in locked compartments and under proper temperature controls, could place residents at risk for drug diversion, drug overdose, exposure to expired drugs, or exposure to drugs that have not been kept at temperatures that are recommended by the drug manufacturer. Findings include: During an observation and interview on 03/11/2020 at 7:40 AM, it was noted that the temperature log sheet on the refrigerator in the medication room was not filled out for the dates of 01/04/2020, 01/05/2020, 01/11/2020, 01/12/2020, 01/18/2020, 01/19/2020, 01/25/2020, 01/26/2020, 02/01/2020, 02/02/2020, 02/08/2020, 02/09/2020, 02/15/2020, 02/16/2020, 02/22/2020, 02/23/2020, 02/25/2020, 02/26/2020, 02/27/2020, 02/28/2020, 02/29/2020, 03/01/2020, 03/07/2020, and 03/08/2020. The refrigerator contained several medications including suppositories, a vial of [MEDICATION NAME] R [MED], and an injection pen of [MEDICATION NAME] [MED]. LVN A reported that the day shift nursing staff are supposed to check the refrigerator temperature and fill on the log once a day. During an observation on 03/11/2020 at 7:48 AM, the medication room was not locked, and no staff members were visible from the medication room door or nurse station area. There were no staff in the medication room. During an interview on 03/11/2020 at 7:50 AM with LVN A, she was asked if the medication room was currently locked. She stated, I thought you locked it when we were in there earlier. During an interview on 03/11/2020 at 2:15 PM, DON reported that the temperature log for the medication room refrigerator is supposed to be filled out once every day. DON confirmed that there were several missed days on the temperature log and claimed that it appeared as if the weekend nurses were not doing it. DON reported that it is her expectation that the medication room stay locked at all times when staff are not actively supervising it. Record review of facility provided policy titled Keys to Drug Storage and Narcotic Areas, not dated, revealed in part: 1. Only persons authorized to set up and administer medications shall have access to the drug room. Record review of facility provided policy titled Storage of Medication, dated 11/2017, revealed in part: Policy The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures 3. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access. 11. Medications requiring refrigeration or temperatures between 2 C (36 F) and 8 C (46 F) are kept in a refrigerator with a thermometer to allow temperature monitoring. A temperature log or tracking mechanism is maintained to verify that temperature has remained within acceptable limits.
F 0912 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that the facility did not provide 80 square feet of floor space per resident in 4 of 23 multi-resident rooms. This practice could result in crowding in resident rooms. Findings include: During an interview on 03/10/2020 at 9:49 AM, at entrance conference, ADM requested to continue the room square footage waiver for 4 rooms (2, 7, 16, and 17). During the general observation tour on 02/05/19 at 10:00 AM the following rooms did not meet the minimum 80 square feet of floor space per resident: room [ROOM NUMBER]- 149.4 square feet for 2 beds room [ROOM NUMBER]- 143.75 square feet for 2 beds room [ROOM NUMBER]- 152.25 square feet for 2 beds room [ROOM NUMBER]- 157.25 square feet for 2 beds Record review of the Texas Health and Human Services Commission Form 3740 Bed Classifications (Number and Location) dated 03/10/2020, stated room numbers 2, 7, 16, and 17 listed 2 beds each.