STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265320	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARTHAGE HEALTH AND REHABILITATION CENTER	1901 BUENA VISTA AVENUE CARTHAGE, MO 64836

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review, the facility failed to check the Nurse Aide (NA) registry prior to hire to ensure new employees did not have a Federal Indicator (a registry that indicated a list of individuals who had a previous incident involving abuse, neglect, or misappropriation of property that would prevent the employee from working in a certified long-term are facility) for one (Licensed Practical Nurse (LPN) A) out of five sampled employees, The facility census was 79. 1. Record review of LPN A's personnel file showed the following: -Hired on 6/4/19; -No documentation the facility completed the NA registry check prior to or upon hire for the employee. During an interview on 3/13/20 at 11:35 A.M., Financial Specialist Assistant B said the following: -LPN A previously worked at the facility from 8/29/17 to 9/1/17. Staff checked NA Registry at that time. -He/she checked LPN A's license prior to his/her most recent hire date, but he/she did not check the NA Registry. During an interview on 3/13/20 at 1:15 P.M., the Administrator said staff should check NA registry on all new hires, even if they were rehired.
F 0760 **Level of harm** - Minimal harm or potential for 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 all residents were free from significant medication errors when staff administered insulin (medication used to help control blood sugar levels) without priming the insulin pen, per standards of practice, prior to administration for one resident (Resident #22). The facility census was 79. Record review of the facility's policy, titled Medication Administration Procedures, Subcutaneous (just under the skin) Injection with [MEDICATION NAME], dated 5/2012, showed the following: -Give the airshot before each injection: Small amounts of air may collect in the needle and insulin reservoir during normal use. To avoid injecting air and to ensure proper dosing follow the steps described below. -Hold the syringe with the needle pointing up and tap the syringe gently so any air bubbles collect in the top of the reservoir; -Dial 2 units; -Holding the syringe with the needle pointing up, tap the insulin reservoir a few times. Still with the needle pointing up, press the button as far as it will go and see if a drop of insulin appears at the needle tip. If not, repeat the process until insulin appears. 1. Record review of Resident #22's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's admission Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 12/31/19, showed the following: -Moderately impaired cognition; -Received insulin injections seven out seven days. Record review of the resident's care plan, last updated 2/7/20, showed staff identified the resident at risk for complications related to diabetes and intervention included administer medications as ordered for diabetes. Record review of the resident's physician order, dated 1/30/20, showed direction for staff to administer [MEDICATION NAME] (a fast-acting insulin) 100 Unit/milliliter (ml) [MEDICATION NAME], 20 units, injected under the skin, three times day before meals. Observations on 3/12/20, at 12:15 P.M., showed Certified Medical Technician (CMT) B placed a needle on the resident's [MEDICATION NAME], dialed the pen to 20 units and administered the insulin to the resident. The CMT did not prime the [MEDICATION NAME] prior to administration. During an interview on 3/12/20, at 12:16 P.M., CMT B said he/she never primed the [MEDICATION NAME]. He/she did not know he/she was supposed to. During an interview on 3/12/20 at 1:00 P.M., Registered Nurse (RN) RN C said he/she always primed the insulin pen by discharging 2 units before dialing the ordered dosage. During an interview on 3/12/20, at 1:19 P.M., the Director of Nursing (DON) said the staff received orientation upon hire. The pharmacy consultant conducted training for insulin pens and observed staff administering medications regularly. Staff should prime the insulin pens by placing a needle on the pen, dialing the pen to 2 units and discharging the 2 units. During an interview on 3/13/2020, at 1:13 P.M., the Administrator said staff should prime the insulin pen before use.
F 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interview and record review, the facility failed to review and update the comprehensive facility assessment annually, in accordance with all applicable Federal requirements. Failure to review and update the comprehensive facility assessment annually could delay the services needed to care for the residents in day-to-day operations and in emergencies. This failure could affect all facility occupants. The facility census was 79. Record review of the facility's assessment policy, undated, showed the following: -It is the policy of this facility that it must conduct and document an individualized facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. -The facility assessment will be conducted at the facility level and may incorporate input from governing body/ownership. -The facility will review and update the facility assessment annually and as necessary whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. -The facility assessment will address or include the following per requirements: -The facility's resident population; -Number of residents and resident capacity; -Care required by the resident population which considers: Types of diseases, conditions, physical cognitive disabilities, overall acuity and other pertinent facts that are present within the facility population. -The facility's resources; -A facility-based and community-based risk assessment, utilizing an all-hazards approach; -The Objective of the facility assessment is to evaluate the resident population and identify the resources needed to provide the necessary care and services the residents require. -The facility assessment shall enable the facility to thoroughly assess the needs of its resident population and required resources to provide the care and services the resident's need-serving as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources needed. -The facility assessment will be conducted at the facility level including the administrator, medical director, a representative of the governing body, and the director of the nursing (DON) at a minimum. The environment operations manager, other department heads, or direct care staff will be involved as needed. -Facility Assessment Update: -The facility will review and update the facility assessment annually and as necessary whenever there is, or the facility plans for, any change that would require substantial modification to any part of the assessment. -Location of the Facility Assessment: -The written facility assessment will be located in the facility administrator's office and will be accessible to appropriate parties upon request. Record review of the Facility's Assessments showed -Staff completed the 2017 facility assessment on 8/29/17. -Staff completed the 2020 Facility Assessment on 3/12/20 (during the annual survey). (There was no other documented facility assessments. During an interview on 3/13/20, at approximately 10:41 A.M., the administrator said the following: -When staff updated the 2020 facility assessment, they found the 2018 assessment in the Corporate computer which he thought was dated October 2018. This assessment was not saved and was deleted. -The facility staff could not find the 2019 Facility Assessment and they did not have a copy of the 2018

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 0838 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Facility Assessment. -Staff looked everywhere for the 2019 Facility Assessment and could not located it. -The last Facility Assessment, dated 8/29/17 was the only one he could find. -The previous administrator said she had completed the 2019 Facility Assessment but he could not find it. -The previous Administrator left on 1/14/20 and the current administrator started on 1/15/20.
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 interview and record review, the facility failed to ensure staff appropriately documented the results of the yearly [MEDICAL CONDITION] (TB) (an infectious disease that generally affects the lungs, but can also affect other parts of the body) skin test for two residents (Resident #9 and #22) and failed to complete the yearly TB signs and symptoms form for one resident (Resident #58) in a selected sample of 18 residents. The facility's census was 79. General requirements for TB testing for residents in Long Term Care Facilities, 19 CSR 20-20.100, reads as follows: -Long-term care facilities shall screen their residents for [MEDICAL CONDITION] using the Mantoux method purified protein derivative (PPD) five [MEDICATION NAME] unit test. Each facility shall be responsible for ensuring all test results are completed and documentation is maintained for all residents; -Within one month prior to or one week after admission, all residents new to long-term care are required to have the initial test of a Mantoux PPD ([MEDICATION NAME] sensitivity test) two-step [MEDICATION NAME] test. If the initial test is negative, the second test can be given after admission and should be given one to three weeks later. -All skin test results are to be documented in millimeters (mm) of induration. -All long-term care facility residents shall have a documented annual evaluation to rule out signs and symptoms of [MEDICAL CONDITION] disease. 1. Record review of Resident #9's face sheet (a document that gives a resident's information at a quick glance) showed the following: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's physician order [REDACTED]. Record review of the resident's Medication Administration Record [REDACTED]. 2. Record review of Resident #22's face sheet showed the following: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's PO, dated 1/8/19 showed direction for staff to administer [MEDICATION NAME] ([MEDICATION NAME] purified protein derivative (PPD) used to help diagnose [MEDICAL CONDITION] (TB) infection) 0.1 ml intradermal yearly, and document the lot number and expiration date in nurse notes. Record review of the resident's MAR indicated [REDACTED].M., a nurse documented the post (TB) administration skin audit as 0. -On 1/11/20, at 8:46 P.M., medication follow-up ([MEDICATION NAME] 0.1 ml vial) completed. (Staff did not document the result of the TB test in millimeters). During an interview on 3/13/20 at 12:17 P.M., the Director of Nursing (DON) said the did not document the TB skin test results in mm because he/she was new employee. Facility staff educated the nurse on reading and documenting TB skin test results. 3. During an interview on 3/13/20 at 11:05 A.M., Licensed Practical Nurse (LPN) D said the following: -Staff read the results within 72 hours and documented the results in millimeters; -Staff documented negative or 0 mm if there was no redness or raised skin. During an interview on 3/13/20 at 12:17 P.M., the Director of Nursing (DON) said the following: -Staff should follow the same TB skin test policy for employees and residents; -Staff should document the results in millimeters or 0 induration. 4. Record review of Resident #58's face sheet showed the following: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's annual signs and symptoms form, dated 8/15/19, showed the following: -Staff did not document a yes or no; -Staff did not document if the resident exhibited signs and symptoms of TB. -The resident did not sign the form. During an interview on 3/13/20 at 12:28 P.M., LPN E said he/she screened the resident and the resident had no signs or symptoms of TB, but he/she did not mark yes or no on the annual statement for [MEDICATION NAME] reactors. During an interview on 3/13/20 at 1:13 P.M., the DON said: -Staff should read and document the results based on facility policy. -Since the resident had a positive TB test in the past, staff had to complete an annual signs and symptoms checklist. -The resident refused to sign the form. -Staff should have completed the annual signs and symptom form.
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.** Based on observation and interview, the facility failed to provide a switch that would activate the resident call light system in four common-use restrooms. This deficient practice had the potential to affect all residents and visitors who used the restrooms and required staff assistance. The facility had a census of 79. 1. Observation on 3/13/20, beginning at 9:00 A.M., showed two unsecured common-use restroom doors, located in the therapy hall, in which residents could access. Staff attached the restroom door key to the outside of each door. Neither restroom had a call light activation switch. 2. Observation on 3/13/20, at 11:30 A.M., showed two unsecured common-use restroom doors, located in the main lobby, in which residents could access. Staff attached the restrooms door key to the outside of each door. Neither restroom had a call light activation switch. 3. During an interview on 3/13/20, at 1:00 P.M., the maintenance supervisor said he did not know the restrooms needed a call light activation switch.