STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265548	A. BUILDING _____ B. WING _____	10/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MINER NURSING CENTER	**410 H ROAD SIKESTON, MO 63801**

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 0624 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Prepare residents for a safe transfer or discharge from the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document preparation and orientation for transfer to the hospital for two residents (Resident #38 and #87) out of 12 sampled residents. The facility's census was 36. 1. Record review of Resident #38's progress notes showed: - The resident transferred to the hospital on [DATE] and not readmitted to the facility. Record review of the resident's medical record did not contain documentation which showed the resident was prepped and oriented for transfer out of the facility. 2. Record review of Resident #87's progress notes showed: - The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]; - The resident transferred to the hospital on [DATE] and readmitted to the facility on [DATE]. Record review of the resident's medical record did not contain documentation which showed the resident was prepped and oriented for transfer out of the facility. During an interview on 10/9/20 at 10:45 A.M., the Director of Nursing (DON) said she was sure the staff were doing that and it is just not documented but they will start doing that. Record review of the facility's policy titled, Discharge/Transfer of Resident, dated March 2015, showed the policy did not address documentation for preparation and orientation for transfer.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the accuracy of assessments for one resident (Resident #10) out of 12 sampled residents. The facility's census was 36. 1. Record review of Resident #10's medical record showed: - A quarterly Minimum Data Set (MDS), a federally mandated assessment to be completed by facility staff, dated 6/30/20, showed the resident had an indwelling urinary catheter (a flexible tube that drains urine from the bladder to a collection bag); - A physician's orders [REDACTED]. Observation on 10/06/20 at 1:33 P.M. showed Resident #10 had no indwelling urinary catheter. During an interview on 10/06/20 at 2:55 P.M., the Director of Nursing (DON) said the resident no longer had a urinary catheter. During an interview on 10/08/20 at 3:45 P.M., the MDS Coordinator said the urinary catheter should not have been on that MDS. He/she had looked through the nurse's notes but had not seen where the catheter had been discontinued. During an interview on 10/09/20 at 10:45 A.M., the DON said she would expect the MDS assessment to be accurate. Record review of the facility's policy titled, Resident Assessment Instrument, dated October 2019, showed Federal regulations require the assessment accurately reflect the resident's status.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement an individualized comprehensive care plan with specific interventions for two residents (Resident #32 and #87) out of 12 sampled residents. The facility's census was 36. 1. Record review of Resident #32's physician's orders [REDACTED]. Record review of the resident's quarterly the Minimum Data Set (MDS, a federally mandated assessment instrument completed by the facility) dated 8/15/20, showed: - Limited physical assistance of one staff for bed mobility, transfers, and toileting; - Extensive physical assistance of one staff for locomotion (moving from one place to another), dressing, personal hygiene, and bathing. Record review of the resident's Fall Risk Assessment, dated 5/22/20, showed moderate fall risk. Record review of the resident's progress notes, dated 8/23/20, showed resident found lying on the floor, able to move all extremities with no pain or discomfort. Resident stated he/she had a bump on his/her head that hurt. Hematoma noted to left side of the resident's head. No other injuries noted. Record review of the resident's comprehensive care plan, updated 3/20/20, showed no interventions or plan of care for falls. 2. Record review of Resident #87's POS, dated 10/1/20 through 10/31/20, showed: - [DIAGNOSES REDACTED]. Record review of the resident's progress notes, dated 5/22/20, showed readmit: - Resident on way back to facility; - New [DIAGNOSES REDACTED]. Record review of the resident's comprehensive care plan, updated 3/20/20, showed no interventions or plan of care for [MEDICAL CONDITION]. During an interview on 10/9/20 at 10:45 A.M., the Director of Nursing (DON) said she would expect a resident at risk for falls to have a care plan addressing falls. She would expect a resident with [MEDICAL CONDITION] to have a care plan addressing [MEDICAL CONDITION]. Record review of the facility's policy titled, Care Plan Comprehensive, dated March 2015, showed: - An individualized comprehensive care plan that includes measurable goals and time frames will be developed to meet the resident's highest practicable physical, mental, and psychosocial well-being; - The comprehensive care plan will be based on a thorough assessment that includes, but is not limited to, the Minimum Data Set (MDS, a federally mandated assessment instrument completed by the facility); - Assessment of each resident is an ongoing process and the care plan will be revised as changes occur in the resident's condition.
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 observation, interview, and record review, the facility failed to revise and update comprehensive care plans with specific interventions to meet the individual needs of two residents (Resident #10 and #87) out of 12 sampled residents. The facility's census was 36. 1. Record review of Resident #10's physician's orders [REDACTED].M. showed Resident #10 did not have an indwelling urinary catheter. Record review of Resident #10's care plan, last reviewed 3/31/20, showed a care plan in place for an indwelling catheter and did not reflect the catheter had been discontinued. 2. Record review of Resident #87's POS, dated 10/1/20 through 10/31/20, showed: - [DIAGNOSES REDACTED].), [MEDICAL CONDITION], hypertension, muscle weakness, toxic metabolic encephalopahy ([MEDICAL CONDITION] from failure of other internal organs)and [MEDICAL CONDITION] (a condition causing damage to the major blood vessels that supply the heart with blood, oxygen, and nutrients.) Record review of the resident's nurse's progress notes showed: - On 5/22/20, readmit, - New [DIAGNOSES REDACTED]. - New order for 1500 milliliter (ml) fluid restriction; - On 8/17/20, resident refused [MEDICAL TREATMENT] today; - On 8/19/20, resident is refusing to go to [MEDICAL TREATMENT] again today; - On 8/26/20, resident refusing to go to [MEDICAL TREATMENT] on this day; - On 8/27/20, resident does not want to go to [MEDICAL TREATMENT] again on this day. Resident sent to hospital for altered mental status and [MEDICAL CONDITION]; - On 9/14/20, resident left [MEDICAL TREATMENT] on 9/11/20 before time to be done, stating he/she didn't feel good. Guardian called with concerns that resident continues to be at times non compliant with this; - On 9/22/20, resident found sitting on bottom in floor, beside bed. No apparent injuries noted. When asked what happened, the resident said he/she slid out of bed onto the floor because the wheelchair doesn't lock right.

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Denied striking head. Record review of the resident's comprehensive care plan, updated 3/20/20, showed: - Care plan not updated with new order for fluid restriction and not placed on intake and output monitoring; - Care plan not updated for refusals of [MEDICAL TREATMENT]; - Care plan not updated with new interventions following fall on 9/22/20. During an interview on 10/08/20 at 3:45 P.M., the Minimum Data Set (MDS, a federally mandated assessment completed by the facility) Coordinator said he/she is responsible for several homes. Some things may have been missed, but any nurse can update the care plans. During an interview on 10/9/20 at 10:45 A.M., the Director of Nursing (DON) said she would expect the care plan to be updated for a resident with a new order for fluid restriction, refusals of [MEDICAL TREATMENT], new interventions after a fall and after an indwelling urinary catheter had been removed. The MDS Coordinator calls on the phone for updates on the residents and makes the residents' changes. The DON said she had not been shown how to make changes in the computer charting and would expect any nurse to be able to update the care plan. Record review of the facility's policy titled, Care Plan Comprehensive, dated March 2015, showed the interdisciplinary care plan team is responsible for the periodic review and updating of care plans when a significant change in the resident's condition has occurred, at least quarterly, and when changes occur that impact the resident's care. Record review of the facility's policy titled, [MEDICAL TREATMENT], Care of a Resident Receiving, dated March 2015, showed: - Residents with fluid restrictions due to [MEDICAL TREATMENT]: The resident will be placed on I&O to monitor the resident's fluid intake and output. The physician will be notified of non-compliance. All the above will be addressed on the care plan as indicated.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician's orders for one resident (Resident #87) out of 12 sampled residents. The facility's census was 36. Record review of the facility's policy titled, [MEDICAL TREATMENT], Care of a Resident Receiving, dated March 2015, showed: - Checking the Thrill Sensation: Nurses will check the thrill daily and document daily. This will be documented on the resident's treatment record. If no thrill sensation is felt, notify the physician; - Residents with Fluid Restrictions due to [MEDICAL TREATMENT]: The resident will not have a water pitcher in their room. The resident will be placed on I&O (intake and output) to monitor the resident's fluid intake and output. The physician will be notified of non-compliance. All of the above will be addressed on the care plan as indicated. Record review of Resident #87's Physician's Order Sheet (POS), dated 9/01/20 through 9/30/20, showed an order written [REDACTED]. Record review of Resident #87's POS, dated 10/01/20 through 10/31/20, showed: - [DIAGNOSES REDACTED].), [MEDICAL CONDITION], hypertension, muscle weakness, toxic metabolic encephalopahy ([MEDICAL CONDITION] from failure of other internal organs)and [MEDICAL CONDITION] (a condition causing damage to the major blood vessels that supply the heart with blood, oxygen, and nutrients); - an order written [REDACTED]. Record review of the resident's Treatment Record showed: - For August 2020, four out of 31 opportunities to check bruit and thrill missed on day shift, 21 out of 31 opportunities missed on evening shift, and three out of 31 opportunities missed on night shift; - For September 2020, four out of 27 opportunities missed on day shift, 19 out of 27 opportunities missed on evening shift, and one out of 27 opportunities on night shift; - For October 2020, no treatment to check bruit and thrill in right arm every shift for 10/1/20 through 10/9/20. During an interview on 10/9/20 at 10:45 A.M., the Director of Nursing (DON) said she would expect treatment orders to be followed as written. She would expect the nurse to check the new POS to make sure it was correct.