STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165466	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RISEN SON CHRISTIAN VILLAGE	**3000 RISEN SON BOULEVARD COUNCIL BLUFFS, IA 51503**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to consult a resident's physician and notify a resident's representative for residents who have an onset of adverse symptoms which represented a change in condition (Resident #7). The facility reported census was 79 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 12/18/19, Resident #7 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS documented Resident #7 had a brief interview for mental status (BI[CONDITION]) score of 3, indicating a severely impaired cognitive status. The MDS also documented Resident #7 required extensive assistance of others with mobility, transfers, dressing, toilet use, and personal hygiene needs. According to an incident report dated 12/25/19 at 2:30 p.m. and written by Staff D, licensed practical nurse (LPN), staff found Resident #7 sitting on her buttocks on her bedroom floor, legs extended, with wheelchair to the side. Assessment revealed range of motion within normal limits with no injuries identified. Staff completed cranial checks, which were negative. Resident #7 stated she didn't fall, and acted in a confused manner, which was normal for her. Staff reminded the resident not to get up without assistance. In an interview on 2/17/20 at 3:51 p.m. Staff D, LPN, stated on the afternoon of 12/25/19 she passed Resident #7's room and found her sitting on the floor in front of her bed. Staff D stated she thought Resident #7 had been in her wheelchair earlier, but was not certain when she had last been seen. Staff D stated she completed an assessment, including range of motion, noting she physically moved Resident #7's upper and lower extremities and noted no restrictions or indications of pain. Staff then transferred Resident #7 from the floor via Hoyer lift and then into bed. Staff D stated she later notified the resident's family and faxed the physician of the fall without injury. Progress note dated 12/26/19 at 4:24 p.m. and written by Staff E, LPN, documented fax sent regarding increased pain in left hip. Resident #7's primary care physician directed staff to fax the information to Resident #7's orthopedic physician, which they did. However, the record did not contain information that confirmed Staff E notified the family of the resident's condition. Progress note dated 12/31/19 at 3:34 p.m. written by Staff E, documented left message for Resident #7's orthopedic physician regarding fluid filled pocket around incision site on left hip area, and received an order to X-ray the resident's left femur. In an interview on 2/17/20 at 1:15 p.m. Staff E, licensed practical nurse, stated she recalled Resident #7 had increased pain in her left hip (12/26/19) following a fall on the day before. Staff E stated she contacted Resident #7's primary care physician, who then told her to contact Resident #7's orthopedic physician. Staff E stated she sent a fax to the orthopedic physician's office, but did not receive a response. Staff E stated she informed the on-coming nurse and asked her to follow up. Staff E reported she did not notify family of the increased discomfort in Resident #7's leg and hip. Staff E stated a few days later (12/31/19) she remembered the fluid filled blisters that had developed on the incision site on Resident #7's left leg. Staff E stated she again faxed the orthopedic physician's office, this time getting orders to x-ray the leg. An in house x-ray was completed and then later the facility sent Resident #7 to the hospital to have a second x-ray. Staff E stated she did not notify family of the fluid filled blisters or of the initial x-ray, but recalled family was aware of the second x-ray taken later that evening. Progress notes dated 12/26/19 through 12/31/19 found no indications of staff following up with with Resident #7's orthopedic physician to address the increased pain level identified by Staff E on 12/26/19. There were no indications Staff E notified Resident #7's family of her condition as it had changed following the fall.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** Based on observation, record review and staff interviews, the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly and comfortable interior. The facility reported census was 39. residents. Findings include: In an interview on 2/19/20 at 3:30 p.m. Staff H, housekeeping supervisor, stated housekeepers are expected to clean every resident room every day which includes sweeping, mopping, wiping down flat surfaces, cleaning toilets, sinks, mirrors and bathroom floors. At the end of each day the housekeeper provides Staff H with a check list of the rooms completed that day. Staff H stated each month every resident room is scheduled to be deep cleaned, which includes moving furniture, wiping down bed frames and a more thorough sweeping, mopping and cleaning of the room. Staff H stated housekeeping will empty trash cans and replace trash bags if soiled briefs are not in them. Aides are responsible for emptying trash cans with soiled briefs and supplies in them, stripping beds, sanitizing mattresses and putting clean linens on the beds. Staff H provided the [LOC] checklist for 2/19/20 in which the housekeeper checked off all rooms as completed and the scheduled deep clean room A 20 was not done. According to a facility map and observation there are 21 occupied resident rooms on Hall A. During observation of housekeeping services on Hall A on 2/18/20, the housekeeper first entered Hall A at 8:30 a.m. and cleaned two rooms, A 05 and A 11, before leaving at 9:00 a.m. By 11:30 a.m. multiple residents had received baths or showers, but staff were not ever observed stripping or sanitizing beds or putting fresh linens on them. Housekeeping returned to Hall A at 12:30 p.m. and was in and out of some rooms, but not all and it was difficult to tell what tasks were completed in each room. A15 bathroom was clean and floor mopped, A18 floor was swept, but no other cleaning task observed, and A19 was mopped, but the bathroom had not been cleaned. Following the housekeeper's shift at 4:00 p.m. the following observations were made: A09 had gloves in the trash can, debris on the floor and a spill under the bed that appeared to have been there for some time, A11 had briefs and gloves in the bathroom trash can, A12 had a cup and paper on the bathroom floor and and the riser on toilet had visible fecal matter on it, A13 had trash left in the bathroom, A15 had gloves left in the bathroom trash can, and A19 had trash remaining in the trash can. During observation of housekeeping services on Hall A on 2/19/20, the housekeeper first entered Hall A at 8:07 a.m. and cleaned rooms A7, A8 and A10. At 9:07 a.m., the housekeeper left the hall. In A19, the trash remained full and untouched from yesterday. The housekeeping staff returned to Hall A at 10:00 a.m. and cleaned rooms A2, A11 and A14. Rooms appeared clean and well swept, however room A14 had trash left in the bathroom. The housekeeper left Hall A at 10:30 a.m. At 11:20 a.m. the housekeeper returned to Hall A, this time sweeping and mopping the lobby before cleaning rooms A13, A15 and A18. A brief was left in A13 bathroom trash can. A blanket was left on A18's bathroom floor and the floor did not appear to have been mopped. The housekeeper moved to A4 and A17. Both rooms were swept and mopped, however papers and debris remained under the recliner in room A17. At 2:57 a.m. the housekeeper was no longer on Hall A. Room A14's bathroom remained untouched with a full trash can, a visibly dirty shower, visible dirt and debris on the floor and visible stool remained on toilet and riser. A9 remained untouched, neither swept nor mopped, and papers, debris, a full trash can, and a spill stain remained under the resident's bed which had been observed for the last two

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

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) days. No beds were observed to have been stripped, sanitized or remade with clean linens. In an interview on 2/18/20 at 4:00 p.m. Resident #9 stated housekeeping services are poor - rooms are not kept clean. Resident #9 pointed to her bathroom with the debris and paper on the floor and paper that remained in the trash can. Resident #9 stated rooms are never deep cleaned monthly and commented her bed had not been stripped, sanitized or made with clean linens, although today was her shower day. In an interview on 2/19/20 at 5:50 p.m. the Director of Nursing (DON), stated bed linens are to be stripped and mattresses sanitized on every bath day and as needed if soiled. SHe added aides are responsible for disposing of any trash that contained briefs or soiled pads. In an interview on 2/19/20 at 5:22 p.m. Staff I, certified nurse aide, stated she completed showers for residents in A11, A16 and A17 and noted A19 never showed up. Staff I also stated three residents scheduled for showers refused. Observations noted of the three residents who received showers and of the four who did not, revealed none of the resident's beds had been stripped, sanitized or made with clean linens.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, the facility failed to provide incontinence cares at a sufficient frequency to maintain the personal hygiene of residents unable to carry out the activity independently (Resident #3). The facility also failed to provide bathing or showering opportunities twice per week to maintain the personal hygiene of residents unable to carry out the activity independently (Residents #1, #3, #5, #9). The facility reported census was 79 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool with assessment reference date of 1/24/20, Resident #3 had a Brief Interview for Mental Status (BI[CONDITION]) score of 15 which indicated an intact cognitive status. Resident #3 required extensive assistance with transfers, ambulation, dressing, toilet use and personal hygiene needs. Resident #3's [DIAGNOSES REDACTED]. Resident #3 is coded as always incontinent of bowel and bladder. During observations on 2/18/20, Resident #3 was provided incontinence cares and assisted into her wheelchair by 8:10 a.m. Resident #3 remained in her wheelchair through 12:33 p.m. at which time her spouse was propelling her to the dining room for lunch. There were no observations during that time frame in which staff were observed checking Resident #3 for incontinence or of staff transferring Resident #3 back into bed and providing incontinence care. During observations on 2/19/20, Resident #3 was provided incontinence cares and assisted into her wheelchair by 11:00 a.m. with spouse visiting. Resident #3 remained in her wheelchair through 5:00 p.m. There no observations during that time frame in which staff were observed checking Resident #3 for incontinence or of staff transferring Resident #3 back into bed and providing incontinence care. In an interview on 2/20/20 at 11:40 a.m. Resident #3 stated she was up around 11:00 a.m. on 2/19/20 and remained up in her wheelchair until 7:30 p.m. Resident #3 and her spouse both indicated Resident #3 was never taken out of her wheelchair during that time and provided incontinence cares or a change of brief. Resident #3's spouse stated this is common when he visits. During observations on 2/20/20, Resident #3 was observed up in her wheelchair with her spouse preparing to go to lunch at 11:40 a.m. Resident #3 stated she did not receive her shower last night noting staff stated they didn't have time and would get it in the morning. Resident #3 stated she got a shower around 6:00 a.m. and has been up in her wheelchair since. At 3:15 p.m. Resident #3 remains in her wheelchair. Resident #3 and her spouse both state Resident #3 has been in her wheelchair since 6:00 a.m. and has not been provided incontinence cares or a change of brief today. Resident #3 and her spouse stated Resident #3 has not received any treatment to her bottom today. BATHING According to the MDS dated [DATE], Resident #1 had a Brief Interview for Mental Status (BI[CONDITION]) score of 14 indicating an intact cognitive status. Resident #1 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs and required physical help with bathing. Resident #1's [DIAGNOSES REDACTED]. In an interview on 2/18/20 at 1:15 p.m. Resident #1 stated she does not always get her baths twice weekly. According to bathing records from 11/1/19 through 2/20/20, Resident #1 has scheduled bathing on Mondays and Thursdays. Resident #1 was not provided an opportunity to bathe on 11/18, 11/25 and 2/17. According to the MDS dated [DATE], Resident #5 had a Brief Interview for Mental Status (BI[CONDITION]) score of 15 which indicated an intact cognitive status. Resident #5 required extensive assistance with transfers, ambulation (walking), dressing, toilet use, and personal hygiene. Resident #5 required physical help with bathing. Resident #3's [DIAGNOSES REDACTED]. In an interview on 2/20/20 at 10:00 a.m. Resident #5 stated she gets bed baths , but would prefer getting showers if they would get a shower chair for her size. Resident #5 stated she will refuse her bed baths depending on who is providing them. Resident #5 stated there was a time in which she wasn't always getting a bed bath twice a week, but she now insists and she thinks it's better. According to bathing records from 11/1/19 through 2/20/20, Resident #5 has scheduled bathing on Tuesdays and Fridays. Resident #5 was not provided an opportunity to bathe on 12/27 and 12/31. According to the MDS dated [DATE], Resident #9 had a Brief Interview for Mental Status (BI[CONDITION]) score of 15 indicating an intact cognitive status. Resident #9 required extensive assistance with mobility, transfers, dressing, toilet use and personal hygiene needs. Resident #9 required physical help with bathing. Resident #9's [DIAGNOSES REDACTED]. In an interview on 2/20/20 at 2:15 p.m. Resident #9 stated she gets showers on Tuesdays and Fridays and rarely refuses them unless offered late in the evening. Resident #9 stated she does not always get her showers. According to bathing records from 11/1/19 through 2/20/20, Resident #9 has scheduled bathing on Tuesdays and Fridays. Resident #9 was not provided an opportunity to bathe on 11/15, 11/19, 1/14, 1/31, 2/7 and 2/14. Resident #9 was recorded as refusing a shower 5 days during that time frame.
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** Based on record review and staff interviews, the facility failed to provide an accurate assessment and timely interventions for a resident with an onset of adverse symptoms which represented a change in condition. (Resident #7). The facility reported census was 79 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 12/18/19, Resident #7 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS documented Resident #7 had a brief interview for mental status (BI[CONDITION]) score of 3, indicating severely impaired cognitive status. The MDS also documented Resident #7 required extensive assistance of others with mobility, transfers, dressing, toilet use, and personal hygiene needs. According to an incident report dated 12/25/19 at 2:30 p.m. and written by Staff D, licensed practical nurse (LPN), staff found Resident #7 sitting on her buttocks on her bedroom floor, legs extended, and wheelchair to the side. Assessment revealed range of motion within normal limits with no injuries identified. Staff completed cranial checks, which were negative. Resident #7 stated she didn't fall, and acted in a confused manner, which is normal for her. In an interview on 2/17/20 at 3:51 p.m. Staff D, LPN, stated on the afternoon of 12/25/19 she passed Resident #7's room and found her sitting on the floor in front of her bed. Staff D stated she thought Resident #7 had been in her wheelchair earlier, but was not certain when she had last been seen. Staff D stated she completed an assessment, including range of motion, noting she physically moved Resident #7's upper and lower extremities and noted no restrictions or indications of pain. Staff then transferred Resident #7 from the floor via Hoyer lift and then into bed. Progress note dated 12/26/19 at 4:24 p.m. and written by Staff E, LPN, documented fax sent regarding increased pain in left hip. Resident #7's primary care physician directed staff to fax the information to Resident #7's orthopedic physician, which they did. Progress note dated 12/31/19 at 3:34 p.m. written by Staff E, states left message for Resident #7's orthopedic physician regarding fluid filled pocket around incision site on left hip area, and received an order to X-ray the resident's left femur. In an interview on 2/17/20 at 1:15 p.m. Staff E, licensed practical nurse, stated she recalled Resident #7 had increased pain in her left hip (12/26/19) following a fall on the day before. Staff E stated she contacted Resident #7's primary care physician, who then referred her to contact Resident #7's orthopedic physician. Staff E stated she sent a fax to the orthopedic physician's office, but did not receive a response. Staff E stated she informed the on-coming nurse and asked her to follow up. Staff E stated she did not complete an assessment on Resident #7's left leg and did not check the range of motion on the leg. Staff E reported a few days later (12/31/19) she remembered the fluid filled blisters the developed on the incision site on Resident #7's left leg. Staff E stated she again faxed the orthopedic physician's office, and received orders to x-ray the leg. An in house x-ray was completed and then later the facility sent Resident #7 to the hospital to have a second x-ray. According to a Radiology report dated 12/31/19 at 11:07 p.m. Resident #7 had a left comminuted and displaced

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) intertrochanteric fracture about the proximal intramedullary nail. A screw projected along the superior portion of the intramedullary nail and may have been a displaced and rotated dynamic compression screw. Additionally there was irregularity along the proximal and lateral aspect of the intramedullary nail, hardware fracture not included. Progress notes dated 12/26/19 through 12/31/19 found no indications of staff following up with with Resident #7's orthopedic physician to address the increased pain level identified by Staff E on 12/26/19. There were also no follow up assessments of Resident #7's left leg related to the fall, despite a reported increased level of pain in that area. There were no indications of Resident #7's family being informed of her condition as it had changed following the fall. It was not until 12/31/19 that Staff E finally made contact with the orthopedic physician and received x-ray orders.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and resident interviews, the facility failed to ensure all residents received care consistent with professional standards of practice to prevent pressure ulcers and also that residents with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing (Resident #3). The facility reported census was 79 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool dated 1/24/20, Resident #3 had a Brief Interview for Mental Status (BI[CONDITION]) score of 15 which indicated an intact cognitive status. The MDS documented the resident required extensive assistance with transfers, ambulation (walking), dressing, toilet use and personal hygiene needs and had [DIAGNOSES REDACTED]. The MDS also documented Resident #3 always experienced bowel and bladder incontinence. The resident's plan of care documented Resident #3 had a potential for pressure injury development with interventions which included administer treatments as ordered, maintain clean and dry skin, and use a barrier cream as needed with incontinence episodes. Resident #3's plan of care also documented the resident as at risk for skin impairment related to immobility and incontinence with interventions that included administer treatments as ordered and monitor for effectiveness. The care plan also directed staff to monitor/remind/assist to turn/reposition for comfort as tolerated. During observations on 2/18/20, Resident #3 was provided incontinence cares and assisted into her wheelchair by 8:10 a.m. Resident #3 remained in her wheelchair through 12:33 p.m. at which time her spouse was propelling her to the dining room for lunch. There were no observations during that time frame when staff were observed checking Resident #3 for incontinence or of staff transferring Resident #3 back into bed and providing incontinence care. During observations on 2/19/20, Resident #3 was provided incontinence cares and assisted into her wheelchair by 11:00 a.m. with spouse visiting. Resident #3 remained in her wheelchair through 5:00 p.m. There were no observations during that time frame in which staff were observed checking Resident #3 for incontinence or of staff transferring Resident #3 back into bed and providing incontinence care. In an interview on 2/20/20 at 11:40 a.m. Resident #3 stated she was up around 11:00 a.m. on 2/19/20 and remained up in her wheelchair until 7:30 p.m. Resident #3 and her spouse both verified Resident #3 was never taken out of her wheelchair during that time and provided incontinence care or a change of brief. Resident #3's spouse stated this is common when he visits. During observations on 2/20/20, Resident #3 was observed up in her wheelchair with her spouse preparing to go to lunch at 11:40 a.m. Resident #3 stated she did not receive her shower last night noting staff stated they didn't have time and would get it in the morning. Resident #3 stated she got a shower around 6:00 a.m. and has been up in her wheelchair since. At 3:15 p.m. Resident #3 remained in her wheelchair. Resident #3 and her spouse both state Resident #3 has been in her wheelchair since 6:00 a.m. and has not been provided incontinence cares or a change of brief today. Resident #3 and her spouse stated Resident #3 has not received a treatment to her buttocks today. In an interview on 2/20/20 at 12:30 p.m. Staff F, licensed practical nurse, stated she has not yet completed Resident #3's wound treatment. Resident #3's treatment administration record obtained at 3:30 p.m. on 2/20/20 directed staff to cleanse the resident's left buttock cleansed with soap and water and have [MED] (barrier cream) applied every shift. The 6-2 shift on 2/20/20 contained initials to show the treatment had been completed during that shift. In an interview on 2/20/20 at 12:35 p.m. Staff G, wound nurse, stated Resident #3 had a pressure area develop on her left buttock which has now resolved, but a macerated area (the softening and breaking down of skin caused by excessive amounts of fluid remaining in contact with the skin or the surface of a wound for an extended period of time) on her coccyx had now developed. Staff G reported the treatment had been soap and water wash with [MED] as a preventative barrier cream. Staff G stated the resident preferred staff complete treatments before she got up in the morning, late afternoon, and around 2:00 a.m.
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 record review and staff interview, the facility failed to ensure residents were free of significant medication errors (Resident #8). Resident #8's sister stated on 1/9/20 she began noticing perioral movements (dyskinesia) around the resident's mouth and questioned whether the resident's new medication used to control these movements was being given. Resident #8's sister was informed the medication administration records indicated the medication was given as ordered. The resident's sister asked repeatedly if the resident had missed a dose and was assured either that it had not been missed or only a limited amount had been missed. During the investigation, it was identified the resident ultimately missed 28 days of the medication or a total of 56 doses. The facility reported census was 79 residents. Findings include: According to the Minimum Data Set (MDS) assessment tool with assessment reference date of 12/13/19, Resident #8 had a Brief Interview for Mental Status (BI[CONDITION]) score of 13 indicating an intact cognitive status. Resident #8 required extensive assistance with transfers, ambulation, dressing, toilet use and personal hygiene needs. Resident #8's [DIAGNOSES REDACTED]. Non-[CONDITION] dementia and drug induced subacute dyskinesia. In an interview on 2/10/20 at 7:00 p.m. Resident #8's sister stated on 1/9/20 she began noticing perioral movements (dyskinesia) around Resident #8's mouth. Resident #8's sister questioned whether a medication ([MED]) used to control these movements was being given. Resident #8's sister was informed the medication administration records indicated the medication was given as ordered. On 1/14/20 Resident #8's sister again inquired as to whether the medication was being given. At that time she was told a dose had been missed due to the nurse being unable to locate the bottle of medication. Resident #8's sister stated the medication ([MED]) is prescribed through the university hospital and is provided in a bottle to Resident #8's sister, who then delivers it to the facility. Resident #8's sister stated she requested the bottle of medication be counted and was told it wouldn't help. On 1/16/20 Resident #8's sister again asked that the pills be counted, noting that she would need to contact the doctor and inform her of the movements and whether doses had been missed. Resident #8's sister stated on [DATE] she again contacted the facility and this time was told there had been doses missed and the doctor had been notified and they would resume the medication at its current dosage. Resident #8's sister stated on 1/20/20 she received a call from the Director of Nursing and was told they were taking steps to ensure the medication would be given as prescribed. Resident #8's sister stated she was later informed 42 doses had been missed. In an interview on 2/12/20 at 12:02 p.m. Staff A, registered nurse, stated one evening Resident #8's sister was questioning whether Resident #8 had a sufficient supply of [MED] and thought Resident #8 was displaying an increased oral dyskinesia symptoms. Staff A stated she checked the bottle and it looked fairly full, but she did not count the pills. Staff A stated there may have been several missed doses. Staff A stated that evening she called the neurologist and left a message that Resident #8 may have doses of [MED] and whether they needed to titrate the dose again. Staff A stated the DON then took over. In an interview on 2/13/20 at 11:29 a.m. Staff B, licensed practical nurse, stated at some point, uncertain of time, she was made aware of family concern whether Resident #8 was receiving [MED] as prescribed as a family member was seeing an increase in oral dyskinesia symptoms. The family requested a count which was done by the DON. Staff B stated staff were re-educated on were the bottle was located. Staff B stated they were unable to determine how many doses were missed. In an interview on 2/12/20 at 6:00 p.m. the Director of Nursing (DON) stated on 1/16/20 Resident #8's sister approached the unit manager concerned Resident #8 was not receiving her [MED] as evidenced by increased oral tardive dyskinesia symptoms. The DON stated she left a detailed message with Resident #8's [MEDICAL CONDITION] specialist. On [DATE] the [MEDICAL CONDITION] specialist returned the DON's call and stated she had spoken with Resident #8's neurologist and there would be no changes at that time. The DON stated the [MED] requires titrating, but she was uncertain how many and how often the medication was being missed. The DON stated she re-educated her staff on where the bottle was located and on [DATE] initiated a shift count requirement to ensure Resident #8 was receiving the [MED] as ordered. The DON stated she did not formally interview any of the nurses, but acknowledges several doses of medication were not given. According to Grievance Form dated 1/16/20 by Resident #8's sister on 1/20/20 the DON counted Resident #8's bottle of [MED] (dated 12/20/19) noting 50 doses remained out of an initial 56 doses received. On 1/24/20 Resident #8's sister provided a new bottle of medication dated [DATE]. Observation on 2/12/20 at 7:50 a.m. noted Resident #8's medications are delivered from

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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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) pharmacy in pre-packaging cellophane rolls, however Resident #8's [MED] is contained in a bottle stored in the lock narcotics compartment in the medication cart. This bottle of medication is delivered by Resident #8's sister on or about every 28 days. Observation on 2/12/20 at 5:45 p.m. noted two bottles labeled as [MED] ([MED]) 12 milligrams. One bottle was dated [DATE] and had 6 doses remaining and the other bottle was dated 12/20/19 and had 54 doses remaining. Review of the labels on both bottles revealed both bottles initially contained 56 doses each, for a total of 112 pills. Resident #8's November 2019 and December 2019 Medication Administration Records (MARs) revealed an order for [REDACTED]. Resident #8 's January 2020 Medication Administration Record [REDACTED]. The area indicated for the 1/14/20 dose contained a code that meant, refer to nurse's notes and the 1/30/20 medication is coded as resident absent from facility. Staff had recorded all other doses recorded as given. Observations, record review and interviews note on or about 12/20/19 a 28 day supply (56 doses) of [MED] was delivered to the facility. According to the December MAR indicated [REDACTED]. According to the January MAR indicated [REDACTED]. On 1/20/20, the DON counted the doses in the bottle dated 12/20/19 and noted 50 doses remained. On 1/24/20 the bottle dated [DATE] was provided to the facility by Resident #8's sister only after she was assured the [MED] was being given. Based on these findings it can be reasonably concluded that staff failed to administer Resident #8's [MED] in excess of 28 days or 56 missed doses leading to a breakthrough of tardive dyskinesia symptoms. It is also clear staff failed to meet professional standards of practice by not verifying medications on hand with medication administration records to ensure all medications were accurately available and properly dosed. Staff also failed to accurately document when they documented the administration of medication ([MED]) that was obviously not given. In an interview on 2/19/20 at 5:06 p.m. Resident #8's neurologist's nurse confirmed she had been in contact with the neurologist and it was the neurologist's understanding Resident #8 had only missed a few doses of [MED]. The neurologist stated missing an entire month of [MED] medication would likely lead to potential side effects, but may not require re-titration. During an observation of a medication pass involving Resident #8, Staff C, registered nurse, appeared to compare the medication labeling with the medication administration record. Staff C then tore open the medication packaging and placed the pills in a medication cup. During that process, a pill fell to the lower ledge of the medication cart, appearing to be unnoticed by Staff C. Staff C then proceeded to place a liquid medication ([MEDICATION NAME]) 1.25 milliliters into a couple ounces of water. As Staff C was gathering his medication cup, he tipped over the glass of water containing the [MEDICATION NAME]. Staff C quickly set the glass back up with an ounce or so of water remaining. Staff C then started to wipe up the water and as he wiped the lower part of the medication cart, grabbed the dropped pill with his bare hands and placed the pill into the medication cup. Staff C then got another 1.25 milliliters of [MEDICATION NAME] and put it in the glass of water which had previously spilled and still had some water and medication in it. When Staff C was alerted he had made a medication error (adding 1.25 mm of [MEDICATION NAME] to water that still contained an unknown amount of medication), he disposed of the glass of water and medication and began again. Staff C then placed 1.25 mm of [MEDICATION NAME] in a new glass with a couple of ounces of water and picked up the other cup that contained pills. At that point, Staff C was alerted it was not sanitary to pick up a loose pill from the ledge of the medication cart and place in a medication cup with other pills. Staff C was also asked if he knew the name of the loose pill. Staff B, Nurse Manager, had observed the interaction and then became involved. Staff B removed the dropped pill from the medication cup, poured all of the medications onto a napkin, and proceeded to identify all of the medications. The dropped medication was identified as a Vitamin C tablet. Another half pill was also found on the floor, identified and replaced. After that, all medications were reconciled and administered properly. In an interview on 3/4/20 at 3:16 p.m. the Director of Nursing stated since implementing Resident #8's shift change count of [MED], there was only the one missed dose in mid-February with no missed doses since. The DON stated she has been in communication with the family daily and the Administrator communicated via e-mail weekly.