STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265225	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JAMES LIVING CENTER	415 SIDNEY STREET, PO BOX 69 SAINT JAMES, MO 65559

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to make a prompt effort to resolve grievances for two residents (Resident #43, and #314). Furthermore, the facility failed to maintain evidence demonstrating the results of all grievances for a period of no less than three years, including those from resident council meetings. The facility census was 67. 1. Review of the facility's Grievance Protocol, undated, shows staff was directed as follows: - The purpose of the Grievance/Complaint Report and Grievance Log is to provide a written record of each resident and family concern and to insure proper follow-up through the appropriate discipline. - The Social Service Director (SSD) is responsible for the program, although the Administrator is ultimately responsible for the proper implementation of the program. The SSD informs the Administrator of each incident. -Any member of the Social Services staff can complete the Grievance Complaint Report. The appropriate situations for use of the Grievance Complaint Report are: -Resident articles that are lost or cannot be located; continual concern of lost resident items. This would include laundry concerns; -Resident care or personal hygiene issues that cannot be immediately resolved; -Resident or family concerns with dietary issues; diet or temperature of the meals; -Any resident or family concern with a staff member; -And any resident or family issue that would require a resolution. -The SSD will: - Obtain the original Grievance Complaint Report; - Record the grievance on the Monthly Grievance Log; - Inform the Administrator of the grievance; - And forward a copy of the grievance to the appropriate discipline. -The Administrator and SSD will evaluate the Monthly Grievance Log for trends or patterns and devise an Action Plan to correct the issues. -A new Grievance Log should be completed each month. It should be presented at the QAA Meeting quarterly. 2. Review of the facility's Concern/Grievance Report, dated 7/1995, shows fill in the blank areas for the date, receipt of concern/grievance, documentation of the facility follow-up, and resolution of the concern/grievance. 3. Review of the facility's Resident Grievance Reminder Form, dated 7/95, shows fill in the blank areas for the date, resident name, who registered the grievance form, who received the form, what the reminder is, action taken, signature, and 2 week follow-up signature. 4. Review of resident #43's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff used to assess the care needs of the resident, dated 03/01/20, showed staff assessed the resident as follows: -Cognitively intact; -Required extensive assistance of two staff members for bed mobility, transfers, and toileting; -Required extensive assistance of one staff member for walking in his/her room, locomotion on and off the unit, eating, and personal hygiene; -And required limited assistance of one staff member for dressing. During an interview on [DATE] at 3:04 P.M., the resident said his/her clock went missing from his/her room on 02/20/20. He/She said he/she reported the incident to the SSD, and two people searched for the clock, but it was never found. Furthermore, he/she said the week prior to reporting his/her clock missing he/she was unable to locate some colored index cards and several compact discs (CDs). He/she said all missing items were reported to the SSD. Review of the facility's grievance log showed it did not contain documentation of the resident's grievance in regards to his/her missing items. During an interview on 03/06/20 at 12:24 P.M., the SSD said the resident did report the missing items to her. She said she did search the resident's room and was able to locate the CDs, but not the clock. The SSD said she did not document the missing clock anywhere. Additionally, she said she did not document the missing items and did not provide the resident a copy of a formal grievance. 5. Review of resident #314's Admission MDS, dated [DATE], showed staff assessed the resident as: - Moderate cognitive impairment; - Required walker for mobility on and off unit; - And required supervision for dressing, toileting, and personal hygiene. During an interview on 3/4/20 at 2:15 P.M., the resident said he/she reported two necklaces and seven dollars missing to the charge nurse, and he/she knows the SSD was made aware of the missing items. He/she said the staff looked for the items, but they were not found. Furthermore, he/she said the items were not replaced by the facility. Review of the facility's grievance log showed it did not contain documentation of the resident's grievance in regards to his/her missing items. 6. During a group meeting on 3/4/20 at 1:31 P.M., members of the resident council complained the evening snacks are always late, and ice water does not get passed. The members continued to say, their complaints have been voiced in meetings before, and have not been resolved. During an interview on 3/6/20 at 2:52 P.M., the Activity Director (AD) said he/she coordinates the resident council meetings, and keeps the meeting minutes. He/she said after meetings, he/she goes to each department with the concerns presented, and tells the residents if concerns have been resolved. The AD said he/she did not know he/she should respond in writing if the facility did not approve the resident council suggestions. Additionally, he/she said he/she did not know he/she was failing to address some of the resident's concerns. During an interview on 03/06/20 at 4:32 P.M., the Administrator said she expected the staff to follow up with all resident grievances, and she followed up with the resident council members after the meeting to address any concerns brought up. She said staff are required to follow the facility policy. Furthermore, she said she does not require any documentation for missed items, since the staff located 99% of them. The administrator said the facility replaced items not located. During an interview on 03/06/20 at 4:32 P.M., the Director of Nursing (DON) said she followed up with the resident council members after the meetings, and talked about any concerns discussed. She said she addressed any nurse related issues with the nursing staff, and held in-service meetings with staff about concerns addressed.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 observation, interview, and record review facility staff failed to develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet the resident's needs for three residents (Resident #26, #34, and #61). The facility census was 67. 1. Review of the facility's Resident Assessment policy, Resident Assessment Instrument (RAI) (a comprehensive assessment and care planning process used in long-term care setting) Guidelines for Care Plans, undated, directed staff as follows: - The initial plan of care will include physician orders [REDACTED]. This may include, but is not limited to the following: - Falls; - Incontinence; - Activities of Daily Living (ADLs) (daily activities such as transfers, dressing, and personal hygiene) assistance; - Meal consumption; - Skin; - Communication; - And elopement risk. 2. Review of resident #26's Quarterly Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff used to assess the care needs of the resident, dated [DATE], showed staff assessed the resident as follows: - Cognitively intact; - Required supervision of one staff member with bed

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) mobility, transfers, walking in room, walking in corridor, locomotion on unit/off unit, dressing, and toilet use; - Required supervision and setup help with eating and personal hygiene; - And [DIAGNOSES REDACTED]. Review of the progress notes showed staff documented the following: -02/04/2020 at 12:08 A.M., Fall: Resident put call light on and aides walked in to see both the mattress and the resident on the floor, resident had complaints of pain in left arm, stated that he/she had landed on his/her arm when he/she had fallen off of his/her mattress on to the ground. Resident said that he/she went to turn in bed and he/she and the mattress flipped on to the floor. The bed frame stayed put and did not turn over. Resident stated that he/she thought his/her arm was broken and wanted to be sent to the emergency room (ER) for examination. Resident rates pain in arm 10/10, left upper arm area is slightly swollen and tender to touch. Resident is unable to move arm without having pain. Notified Director of Nursing (DON) and call center before sending to ER. Vital Signs (VS): Blood pressure (BP) 135/60, Pulse 80, Respiratory rate (RR) 18, Temperature 98 degrees, 97% [MED]gen saturation ([MED]gen level, normal range between 96% and 98%) on room air (RA). Called family member, who did not answer, left voicemail to call at earliest convenience. -02/04/2020 at 5:06 A.M., the resident returned from ER via facility transportation with a [DIAGNOSES REDACTED]. Prescription for [MEDICATION NAME] (medication to treat pain) 1 tablet every 4 hours as needed, faxed. Review of the care plan dated 2/04/20, showed staff were directed to provide care as follows: -Resident is at risk for falls related to impaired mobility, impaired safety awareness, unsteady gait, lower extremity weakness, and left sided [MEDICAL CONDITION]; - Bed to have two locked wheels and the mattress is to be secured at the foot and head with elastic; - And wear appropriate footwear to reduce slipping during transfer and ambulation. Observation on 03/05/20 at 3:28 P.M., showed the resident in his/her bed with his/her eyes closed. Further observation showed the resident did not have non-skid socks on. Observation on 03/06/20 at 10:47 A.M., showed the resident's mattress was not secured to the bed frame and slipped when moved. Observation on 3/06/20 at 4:41 P.M., showed the DON pulled on the mattress, from the middle, with moderate force. Observation showed the mattress moved approximately six inches off of the bedframe. Further observation showed when the DON pulled the mattress from the bed, with gentle force, the mattress slid off of the bedframe. During an interview on 03/06/20 at 10:47 A.M., the resident said he/she tried to turn over in his/her bed and fell to the floor with his/her mattress when he/she broke his/her arm. During an interview on 03/06/20 at 10:54 A.M., Certified Nursing Assistant (CNA) D said he/she was aware the resident fell out of bed, but he/she not sure of all the details. CNA D said staff direct the resident to use the call light. Furthermore, CNA D said the resident is cognitive and is somewhat self-reliant, and he/she mostly requires assistance with transfers and toileting. Additionally, CNA D said he/she was not aware of any fall interventions that involved the resident's mattress. During an interview on 03/06/20 at 10:56 A.M., Registered Nurse (RN) E, said the resident fell on night shift and he/she knew the mattress slid off the bed with the resident when he/she fell . Furthermore, RN E said he/she was not aware of any interventions put in place to prevent a future fall. During an interview on 03/06/20 at 10:56 A.M., Licensed Practical Nurse (LPN) F said he/she was not aware of any interventions put in place to prevent a future fall. During an interview on 03/06/20 at 4:18 P.M., the DON said the resident told her he/she rolled out of bed, and the mattress slid to the floor with him/her. She said the resident said his/her covers were tucked under him/her when he/she rolled out of the bed with the mattress. Furthermore, she said the resident was not previously a fall risk, and he/she has had no falls since he/she broke his/her arm. The DON said the mattress was secured to the frame. The DON said if there are interventions listed on the care plan, he/she expected the staff to mostly follow the care plan. Additionally, she said she gives the staff a day or two to become familiar with the most recent updated care plan. 3. Review of Resident #34's Minimum Data Set (MDS), a federally mandated assessment tool, dated 12/6/19, showed staff assessed the resident as follows: - Mild cognitive impairment; - Required total assistance from staff with eating, with nutritional approach of feeding tube; - And [DIAGNOSES REDACTED]. With meals at 7 A.M., 12 P.M., and 5 P.M. Review of the resident's care plan, with reviewed/revised date of 12/09/19, showed the resident was to receive 100% of his/her nutritional intake via tube feeding. Furthermore, the care plan showed the resident was to be NPO. The care plan did not contain guidance for the staff in regards to the crushed ice chips, suckers, or pureed food. Observation on 3/4/20 at 12:30 P.M., showed the resident in dining room eating a pureed meal. Observation on 3/5/20 at 12:00 P.M., showed the resident in dining room eating a pureed meal. Observation on 3/6/20 at 3:15 P.M., showed the resident in the dining room eating ice cream. During an interview on 3/6/20 at 3:15 P.M., LPN B said the resident is allowed to get a small amount of pureed food at meal times. He/She said they believe it was an order by Occupational Therapy (OT) through the doctor, he/she thinks it is for pleasure eating. 4. Review of Resident #61's quarterly MDS, dated [DATE], showed staff assessed the resident as follows: - Severe cognitive impairment; - Required total assistance from staff with toileting and bathing; - Required extensive assistance with all transfers, dressing, and eating; - And at risk for pressure ulcers. Review of the resident's POS, dated 12/09/19, showed an order for [REDACTED].M.-2 P.M., 2 P.M.-10 P.M., 10 P.M.-6 A.M. Review of the resident's care plan, with a start date of 11/11/19, showed staff were directed to apply heel protectors or float heels as indicated. Observation on 3/3/20 at 12:10 P.M., showed staff transferred the resident from his/her wheelchair to his/her bed. Further observation showed staff did not float the resident's heels, or apply heel protectors as directed by the resident's plan of care. Observation on 3/4/20 at 2:20 P.M., showed the resident in his/her bed. Further observation showed the resident's heels were not floated, and he/she did not have his/her heel protectors on. Observation on 3/5/20 at 11:00 A.M., and 3:30 P.M., showed the resident in his/her bed. Further observation showed the resident's heels were not floated, and he/she did not have his/her heel protectors on. Observation on 3/6/20 at 10:30 A.M., showed the resident in his/her bed. Further observation showed the resident's heels were not floated, and he/she did not have his/her heel protectors on. During an interview on 3/6/20 at 3:00 P.M., CNA C said the resident is to wear his/her heel protectors when in bed. During an interview on 3/6/20 at 3:35 P.M., RN A said the resident should be wearing heel protectors everyday while in bed. He/She said the resident's heels are soft/mushy and the protectors are a preventive measure. He/She said they would expect CNA's and nurses to make sure they are on the resident when he/she is in bed, or at least have his/her heels floated. Furthermore, RN A said what is on the care plan is what is expected to be followed in regards to caring for the resident. During an interview on 3/6/20 at 4:20 P.M., the Administrator and DON said they would expect a residents care plan to reflect nutritional status, orders for heel protectors and interventions for falls. They said they would expect the orders and interventions on the care plan to be followed.