STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	1505 MINER, PO BOX 248 SARCOXIE, MO 64862

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 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, form Center for Medicare and Medicaid Services (C[CONDITION])-) or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits for two residents (Resident #8 and #14) out of a sample of two residents reviewed, who remained in the facility after discharge from Medicare Part A services. The facility census was 30. Record review of the Centers for Medicare and Medicaid Services (C[CONDITION]) Survey and Certification memo (S&C -,[DATE]), dated [DATE], showed the following information: -If the skilled nursing facility (SNF) believes on admission or during a resident's stay that Medicare will not pay for skilled nursing or specialized rehabilitative services and the provider believes that an otherwise covered item or service may be denied as not reasonable or necessary, the facility must inform the resident or his/her legal representative in writing why these specific services may not be covered and the beneficiary's potential liability for payment for the non-covered services. The SNF's responsibility to provide notice to the resident can be fulfilled by use of either the SNFABN (form C[CONDITION]-) or one of the five uniform denial letters; -The SNFABN provides an estimated cost of items or services in case the beneficiary had to pay for them his/her self or through other insurance they may have; -If the SNF provides the beneficiary with either the SNFABN or a denial letter at the initiation, reduction, or termination of Medicare Part A benefits, the provider has met its obligation to inform the beneficiary of his/her potential liability for payment and related standard claim appeal rights. 1. Record review of Resident #8's Skilled Nursing Facility Beneficiary Protection Notification Review, completed by staff on [DATE], showed the following information: -Medicare Part A skilled services started [DATE]; -Last covered day of Medicare Part A service was [DATE]; -The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted; -Facility staff provided the resident or his/her legal representative the Notice of Medicare Non-Coverage (NOMNC) form C[CONDITION]- , which was signed by the resident on [DATE]; -Facility staff did not provide the resident with the SNFABN form C[CONDITION]- , which could have shown documentation of any information in the section specifying the care, reason Medicare might not pay, and the estimated cost; -Staff noted on the form the resident did not receive the SNFABN form because the NOMNC was provided to the resident; -The resident remained in the facility after Medicare Part A services ended. 2. Record review of Resident #14's Skilled Nursing Facility Beneficiary Protection Notification Review, completed by staff on [DATE], showed the following information: -Medicare Part A skilled services started [DATE]; -Last covered day of Medicare Part A service was [DATE]; -The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted; -Facility staff provided the resident or his/her legal representative the Notice of Medicare Non-Coverage (NOMNC) form C[CONDITION]- , which was signed by the resident or representative on [DATE]; -Facility staff did not provide the resident with the SNFABN form C[CONDITION]- , which could have shown documentation of any information in the section specifying the care, reason Medicare might not pay, and the estimated cost; -Staff noted on the form the resident did not receive the SNFABN form because the NOMNC was provided to the resident; -The resident remained in the facility after Medicare Part A services ended. 3. During an interview on [DATE], at 1:03 P.M. and 3:09 P.M., the Social Services Director (SSD) said the following: -As for SNFABN notices, she is only sending NOMNOC forms and not the SNFABN (C[CONDITION]-). She has only been sending the one in the facility's electronic record system for discharges. -She did not know of the C[CONDITION] requirement for providing both the SNFABN and NOMNOC notices to the resident when the resident discharged from Medicare A services and remained in the facility after their Medicare A benefits had expired. 4. During an interview on [DATE], at 3:00 P.M., the administrator said the following: -She did not know of the SNF Beneficiary Notification Policy for residents staying in the facility after Medicare A benefits were discontinued. The facility doesn't have a policy, but she thought the facility had been following the guidelines on the C[CONDITION] website.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for the transfer, for two residents (Resident #8 and Resident #34) out of a sample of 15 residents. The facility census was 30. Record review of the facility's policies showed the facility did not have policies regarding the provision of written notices to residents or representatives, or to the ombudsman, when an emergency transfer to the hospital had occurred. 1. Record review of Resident #34's significant change Minimum Data Set (MDS), a federally mandated comprehensive assessment instrument, completed by facility staff, dated [DATE], showed the following information: -Cognitively intact; -Required extensive assistance for bed mobility, toilet use, and personal hygiene; -Required total dependence on staff for transfers; -[DIAGNOSES REDACTED]. Record review of the nurses' notes, dated [DATE], at 7:44 A.M., showed at 7:42 A.M., the nurse entered the resident's room. The resident lay in bed, alert and able to voice all needs. The resident sat up to the edge of the bed with assist from two aides. The resident became unresponsive and began [MEDICAL CONDITION] activity. The resident had foamy white discharge from his/her mouth present. Assessment showed no pulse and no respirations detected. Staff immediately initiated cardiopulmonary resuscitation (CPR, an emergency procedure that is performed when a person's heartbeat or breathing has stopped) . Staff called 911. Staff notified the resident's family member. CPR continued with the local fire department, arriving at 8:04 A.M., apical pulse (heart rate detected with stethoscope placed on the chest) palpated. Radial pulses (heart rate detected by feeling at the wrist) palpated and the resident began agonal respirations (brainstem reflex characterized by gasping that occurs because the heart is no longer circulating [MED]gen-rich blood). Staff placed a non-rebreather mask (device used to allow delivery of higher concentrations of [MED]gen) at 8 liters of [MED]gen with [MED]gen saturation level registering at 96%. The resident opened his/her eyes and moaned. The emergency medical services (E[CONDITION]) arrived at 8:12 A.M. and the nurse gave a verbal report. Staff transferred the resident to the gurney. The resident was alert at the time of transfer from the facility. The resident's family member arrived to the facility at the time of transfer and followed the ambulance to the emergency room . All pertinent paperwork sent with E[CONDITION]. Record review of the nurses' notes, dated [DATE], at 1:47 P.M., showed the family member notified the facility the resident had just passed away at the hospital. Record review of the resident's medical record showed staff did not have a copy of a written notice sent to the resident or representative regarding the transfer/discharge to the hospital on [DATE] , including the reason for the transfer to the hospital. During an interview on [DATE], at 10:43 A.M., the Assistant Director of Nursing (ADON) said the facility did not

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	1505 MINER, PO BOX 248 SARCOXIE, MO 64862

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) do a written notification of Resident #34's transfer to the hospital because family was at the facility. 2. Record review of Resident #8's significant change MDS, dated [DATE], showed the following information: -Resident had [DIAGNOSES REDACTED]. Record review of the resident's nurses' notes showed the following information: -On [DATE], at 5:10 P.M., the resident reported he/she was short of breath. Observation showed the resident gasping for air. The resident had [MED]gen at three liters/minute via nasal cannula (tubing worn and inserted in the nasal passages for delivery of the [MED]gen). The resident's [MED]gen saturation level (estimated measurement of [MED]gen saturation of capillary blood) registered at 90 percent. The resident's respirations were labored and diaphragmatic (muscles of diaphragm used which could indicate labored breathing). Staff checked the resident's vital signs. Staff notified the physician's office and received orders to send the resident to the hospital emergency room (ER) for further evaluation. -At 5:20 P.M., facility staff notified the hospital E[CONDITION] of the resident's need to be urgently transported from the facility to the hospital ER, and E[CONDITION] personnel arrived to the facility at 5:40 P.M. -At approximately 5:50 P.M., the resident left the facility via ambulance, accompanied by hospital E[CONDITION] staff. Following his/her departure, facility staff called report to the hospital ER. Record review of the resident's medical record showed staff did not notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for the transfer, when the resident transferred to the hospital on [DATE]. Record review of the nurses' notes showed the following information: -On [DATE], at 7:44 A.M., the nurse called the physician's office and updated staff to recent events and acute changes. The physician's office gave a verbal order to transfer the resident to the ER for evaluation and treatment of [REDACTED].M., the nurse called the resident's family member with an update and advised him/her of the new order. The family member agreed and will meet the resident at the hospital. The charge nurse advised the resident of the new order for transfer, and he/she voiced understanding. Facility staff called the hospital for a non-emergent transport to the hospital; -On [DATE], at 8:16 A.M., two hospital Emergency Medical Transport (EMT) staff arrived at facility. Staff transferred the resident to the gurney. All pertinent paperwork sent with EMT staff for ER evaluation. Record review of the resident's medical record showed staff did not notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for the transfer, when the resident transferred to the hospital on [DATE]. Record review of the nurses' notes showed the following information: -On [DATE], at 8:51 A.M., staff assessed and documented the resident's vital signs. The resident could verbalize any needs at this time. The resident moved his/her head from the left and right and moaned. The resident's skin was cool to touch and [CONDITION] (sweaty). Respirations were even and unlabored. The nurse called the physician's office and received a verbal order to transport the resident to the ER for evaluation and treatment. The nurse called the hospital E[CONDITION] and they were in route to the facility; -On [DATE], at 8:59 A.M., the nurse called the resident's family member and left a message requesting a return call; -On [DATE], at 9:05 A.M., the resident's family member called back and staff told the family member of the acute status change and order to transfer the resident to the ER for evaluation and treatment. The family member agreed; -On [DATE], at 9:22 A.M., two hospital E[CONDITION] staff arrived and assisted staff to transfer the resident to the gurney. The resident aroused briefly with somewhat coherent speech then became non-arousable upon departure. Copies of all pertinent paperwork sent with the EMTs for hospital review. The nurse called the family member with an update that E[CONDITION] was transporting the resident to the hospital. The family member voiced understanding, and said he/she would meet them at the ER. Staff told the administrator and Director of Nursing (DON) of the transfer. Record review of the resident's medical record showed staff did not notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for the transfer, when the resident transferred to the hospital on [DATE]. Record review of the nurses' notes, showed the following information: -On [DATE], at 2:46 P.M., the staff member who accompanied the resident to the medical appointment today returned and said the resident admitted to the hospital. The facility did not receive any information regarding the admission. Facility staff called the hospital to obtain the admitting [DIAGNOSES REDACTED]. Record review of the resident's medical record showed staff did not notify the resident and/or the resident's representative in writing of a transfer or discharge to a hospital, including the reasons for the transfer, when the resident transferred to the hospital on [DATE]. 3. During an interview on [DATE], at 12:35 P.M., Licensed Practical Nurse (LPN) D and Registered Nurse (RN) H both said they do not give out written transfer notices or bed hold notices to residents, family, or the ombudsman when a resident is sent out to the hospital emergently, but they do call the administrator, DON, and ADON if the transfer occurs on a weekend. 4. During an interview on [DATE], at 1:03 P.M., the Social Services Director (SSD) said the following: -She keeps track of hospitalization s and sends a notice to the ombudsman monthly regarding hospitalization s. She doesn't have a form she uses for transfer notifications to be given to residents or representatives to sign for the transfer. She doesn't know what the form is for the resident or responsible party to sign for those notifications. The nurses call families when a resident is transferred. 5. During an interview on [DATE], at 3:00 P.M., the administrator said the following: -She did not know of the requirement to send written notifications to residents or responsible parties for emergency transfers to the hospital. The facility does not have a policy regarding written notices for reasons for the hospital transfers to be given to the resident, but she thought she was following the guidelines on the Centers for Medicare and Medicaid (C[CONDITION]) website.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident and/or the resident's representative in writing of the bed hold policy at the time of transfer to the hospital for two residents (Resident #34 and #8). The facility census was 30. Record review of the facility's policies showed the facility had no policies regarding the provision of written notice of the bed hold policy to residents or representatives, or the ombudsman, when an emergency transfer to the hospital had occurred. 1. Record review of Resident #34's significant change Minimum Data Set (MDS), a federally mandated comprehensive assessment instrument, completed by facility staff, dated [DATE], showed the following information: -Cognitively intact; -Required extensive assistance for bed mobility, toilet use, and personal hygiene; -Required total dependence on staff for transfers; -[DIAGNOSES REDACTED]. Record review of the nurses' notes, dated [DATE], at 7:44 A.M., showed at 7:42 A.M., the nurse entered the resident's room. The resident lay in bed, alert and able to voice all needs. The resident sat up to the edge of the bed with assist from two aides. The resident became unresponsive and began [MEDICAL CONDITION] activity. The resident had foamy white discharge from his/her mouth present. Assessment showed no pulse and no respirations detected. Staff immediately initiated cardiopulmonary resuscitation (CPR, an emergency procedure that is performed when a person's heartbeat or breathing has stopped) . Staff called 911. Staff notified the resident's family member. CPR continued with the local fire department, arriving at 8:04 A.M., apical pulse (heart rate detected with stethoscope placed on the chest) palpated. Radial pulses (heart rate detected by feeling at the wrist) palpated and the resident began agonal respirations (brainstem reflex characterized by gasping that occurs because the heart is no longer circulating [MED]gen-rich blood). Staff placed a non-rebreather mask (device used to allow delivery of higher concentrations of [MED]gen) at 8 liters of [MED]gen with [MED]gen saturation level registering at 96%. The resident opened his/her eyes and moaned. The emergency medical services (E[CONDITION]) arrived at 8:12 A.M. and the nurse gave a verbal report. Staff transferred the resident to the gurney. The resident was alert at the time of transfer from the facility. The resident's family member arrived to the facility at the time of transfer and followed the ambulance to the emergency room . All pertinent paperwork sent with E[CONDITION]. Record review of the nurses' notes, dated [DATE], at 1:47 P.M., showed the family member notified the facility the resident had just passed away at the hospital. During an interview on [DATE], at 10:43 A.M., the Assistant Director of Nursing (ADON) said facility staff made it clear Resident #34's bed would be available when he/she came back. Staff did not give the resident or family a copy of the bedhold policy at the time of transfer. The facility gives residents and families the bedhold policy on admission. 2. Record review of Resident #8's nurses' notes showed the following information: -On [DATE], at 5:10 P.M., the resident reported he/she was short of breath. Observation showed the resident gasping for air. The resident had [MED]gen at three liters/minute via nasal cannula (tubing worn and inserted in the nasal passages for delivery of the [MED]gen). The resident's [MED]gen saturation level (estimated measurement of [MED]gen saturation of capillary blood)registered at 90

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	1505 MINER, PO BOX 248 SARCOXIE, MO 64862

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 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) percent. The resident's respirations were labored and diaphragmatic (muscles of diaphragm used which could indicate labored breathing). Staff checked the resident's vital signs. Staff notified the physician's office and received orders to send the resident to the hospital emergency room (ER) for further evaluation. -At 5:20 P.M., facility staff notified the hospital emergency medical system (E[CONDITION]) of the resident's need to be urgently transported from the facility to the hospital ER, and E[CONDITION] personnel arrived to the facility at 5:40 P.M. -At approximately 5:50 P.M., the resident left the facility via ambulance, accompanied by hospital E[CONDITION] staff. Following his/her departure, facility staff called report to the hospital ER. Record review of the resident's medical record showed staff did not notify the resident or responsible party in writing of the bed hold policy when the resident transferred to the hospital on [DATE]. Record review of the nurses' notes showed the following information: -On [DATE], at 7:44 A.M., the nurse called the physician's office and updated staff to recent events and acute changes. The physician's office gave a verbal order to transfer the resident to the ER for evaluation and treatment of [REDACTED].M., the nurse called the resident's family member with an update and advised him/her of the new order. The family member agreed and will meet the resident at the hospital. The charge nurse advised the resident of the new order for transfer, and he/she voiced understanding. Facility staff called the hospital for a non-emergent transport to the hospital; -On [DATE], at 8:16 A.M., two hospital Emergency Medical Transport (EMT) staff arrived at facility. Staff transferred the resident to the gurney. All pertinent paperwork sent with EMT staff for ER evaluation. Record review of the resident's medical record showed staff did not notify the resident or responsible party in writing of the bed hold policy when the resident transferred to the hospital on [DATE]. Record review of the nurses' notes showed the following information: -On [DATE], at 8:51 A.M.: staff assessed and documented the resident's vital signs. The resident could verbalize any needs at this time. The resident moved his/her head from the left and right and moaned. The resident's skin was cool to touch and [CONDITION] (sweaty). Respirations were even and unlabored. The nurse called the physician's office and received a verbal order to transport the resident to the ER for evaluation and treatment. The nurse called the hospital E[CONDITION] and they were in route to the facility; -On [DATE], at 8:59 A.M., the nurse called the resident's family member and left a message requesting a return call; -On [DATE], at 9:05 A.M., the resident's family member called back and staff told the family member of the acute status change and order to transfer the resident to the ER for evaluation and treatment. The family member agreed; -On [DATE], at 9:22 A.M., two hospital E[CONDITION] staff arrived and assisted staff to transfer the resident to the gurney. The resident aroused briefly with somewhat coherent speech then became non-arousable upon departure. Copies of all pertinent paperwork sent with the EMTs for hospital review. The nurse called the family member with an update that E[CONDITION] was transporting the resident to the hospital. The family member voiced understanding, and said he/she would meet them at the ER. Staff told the administrator and Director of Nursing (DON) of the transfer; Record review of the resident's medical record showed staff did not notify the resident or responsible party in writing of the bed hold policy when the resident transferred to the hospital on [DATE]. Record review of the nurses' notes, showed the following information: -On [DATE], at 2:46 P.M., the staff member who accompanied the resident to the medical appointment today returned and said the resident was admitted to the hospital. The facility did not received any information regarding the admission. Facility staff called the hospital to obtain the admitting [DIAGNOSES REDACTED]. Record review of the resident's medical record showed staff did not notify the resident or responsible party in writing of the bed hold policy when the resident transferred to the hospital on [DATE]. 3. During an interview on [DATE], at 12:35 P.M., Licensed Practical Nurse (LPN) D and Registered Nurse (RN) H both said they do not give out bed hold policy notices to residents or family when a resident is sent out to the hospital emergently, but they do call the administrator, DON, and Assistant Director of Nursing (ADON) if the transfer occurs on a weekend. 4. During an interview on [DATE], at 1:03 P.M. and 3:09 P.M., the Social Services Director (SSD) said the following: -She keeps track of hospitalization s and sends a notice to the ombudsman monthly regarding hospitalization s. She doesn't have a form she uses to be given to the resident or resident representative to sign for the bed hold policy. -She did not know that a bed hold policy notification also had to be sent to the resident when a resident transferred emergently to the hospital. The fax she sends to the ombudsman showed the reason for the transfer, not the bed hold policy. 5. During an interview on [DATE], at 3:00 P.M., the administrator said the following: -She did not know of the requirement to send written notifications to residents or responsible parties of the bed hold policy at time of transfer. Residents are notified of the bed hold policy on admission, but not during emergency transfers. The facility does not have a policy regarding written notices for the bed hold policy after an emergency transfer that is to be given to the resident, but she thought she was following the guidelines on the Centers for Medicare and Medicaid (C[CONDITION]) website.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff transferred residents safely to prevent accidents for one resident (Resident #9) out of a sample of 15 residents in a facility with a census of 30. Record review of the facility's (undated) policy titled, transferring residents, showed the following information: -Never transfer a resident by lifting him/her under the arms. This can cause nerve damage, fractures, and shoulder dislocation; -Do not attempt to transfer a resident who cannot bear any of his/her own body weight by yourself; -Determine beforehand how many people are needed for the transfer. If it takes more than two persons to transfer the resident, use a mechanical lift; -Resident should wear footwear with nonskid soles; -Resident's feet should be flat on the floor approximately 12 inches apart; -The purpose of using a gait belt is to ensure optimum safety and comfort for the resident, to minimize the risk of injury to the resident and/ or nurse assistant(s), to facilitate proper body mechanics of the nurse assistant. It allows for better control of the resident while transferring; -The nurse assistant should not transfer or ambulate residents by grasping their upper arms or under their arms. Such a transfer could result in skin tears, damage to nerve and arteries, and possible dislocation of the shoulder; -The nurse assistant grasps the belt on both sides of the resident's waist. Palms should be inserted between the belt and resident with fingertips pointing upwards; -If the resident is non-weight bearing, the nurse assistant should transfer him/her using a mechanical lift. Record review of an (undated) document posted in the facility titled, Attention All Staff showed the following information: -Please notify director of nursing (DON) if you are lifting more than 35 pounds of a resident's weight during transfers. -Or if you are lifting more than 70 pounds of a resident's weight with a two person lift; -Or if the resident becomes non-weight bearing. 1. Record review of Resident #9's full care plan, dated 7/19/2019, showed the following information: -The resident had falls in the past. The resident's family wanted him/her to be free from serious injury if the resident fell . -Assist the resident to get out of bed if the resident tries to get out of bed. -Keep the resident's bed in low position and put a fall mat on the floor when the resident is in bed. -The care plan did not address how staff should transfer the resident or how many staff were required to safely transfer the resident. Record review of the resident's certified nursing assistant (CNA) care plan, dated 10/15/19, showed the following information: -Required two people and a gait belt to transfer. -Keep the resident's bed in a low position unless staff is in the room. Record review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 12/31/19, showed the following information: -[DIAGNOSES REDACTED]. Record review of nurses' notes, dated [DATE], showed the following information: -While transferring the resident from the bed to the wheelchair, the resident lost footing and the aide lowered him/her to the floor. The resident did not strike his/her head. Staff did not observe any injuries. With a two person assist, staff placed the resident in the wheelchair. Record review of the resident's current full care plan, dated [DATE], the DON documented an update in the care plan for staff to put nonskid shoes or socks on the resident during transfers. The care plan did not address how staff should transfer the resident or how many staff were required to safely transfer the resident. Record review of an incident report, dated [DATE], showed the following information: -Registered Nurse (RN) E reported the incident that occurred on [DATE], at 6:05 A.M.; -CNA F transferred the resident from the bed and the resident slipped. Staff sat the resident down on the floor. Staff documented @ person assist. Staff placed the resident in his/her wheelchair. The resident did not have any injury. -Was bed height adjustable? No -Bed height position: No. During an interview on [DATE], at 6:46 A.M., RN E said the resident has a fall mat by his/her bed. The resident thinks he/she can walk but the resident cannot. The resident's fall occurred during a transfer on [DATE]. The resident had to be sat down as the staff wasn't very big and could not keep the resident up. The resident became dead weight while the aide transferred the resident and the resident just didn't give a damn. After the fall/transfer, the facility now uses two staff to transfer the resident and staff can use a gait belt. At

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	1505 MINER, PO BOX 248 SARCOXIE, MO 64862

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) the time of the incident, the resident had been assisting with transfers and bearing weight, and only needed one staff to assist in transfers. Observation on 3/11/2020, at 9:59 A.M. showed the following: -CNA B and CNA I assisted the resident in incontinent care. -The resident's bed was in a high position, above waist level. The resident wore yellow non-skid socks. -Staff assisted the resident to a sitting position and helped turn the resident to the edge of the bed so that the resident's bottom was at the edge of the bed with his/her back facing the wall and feet in front of the resident. -The resident's feet dangled at the edge of the bed about six to eight inches above the floor, unable to touch the floor. -Staff placed a gait belt around the resident's waist. -Both staff held the resident under his/her armpits on each side and lifted the resident under the armpits during the transfer from the bed to the wheelchair. The resident's feet dangled 6-8 inches off the floor. Staff did not touch the gait belt or have the resident assist with the transfer during the entire duration of the transfer. -The resident yelled, Weeeeee! as the staff lifted him/her into the air from the bed to the wheelchair. Staff then removed the resident's gait belt. Observation and interview on [DATE], at 2:10 P.M., showed CNA B and CNA C in the resident's room. CNA B tried to calm the resident as the resident repeated, Jesus take me with you. CNA B said staff normally do a two person transfer with a gait belt but they are doing the Hoyer lift (a mechanical device with a sling attached to lift to transfer a non-ambulatory resident) today because CNA B complained of having a bad back and did not feel comfortable lifting the resident. CNA B and CNA C placed the Hoyer lift sling around the resident's body. CNA B attached the Hoyer sling to the Hoyer lift. CNA B operated the Hoyer lift and raised the lift. CNA B transferred the resident from the bed to the wheelchair. CNA C lowered the resident into his/her wheel chair using the mechanical lift while CNA B remained within arm's reach of the resident. During an interview on [DATE], at 2:10 P.M., CNA B said: -Sometimes the resident will bear weight; but other days he/she will not. -The resident has always been a two person transfer. -The resident used to transfer as a one person assist at least one year ago. -When using the gait belt, staff should hold onto the gait belt with one hand while holding onto the resident's arm with the other hand. -The aide keeps the resident's bed in a higher position so when he/she transfers the resident, gravity can help the aide, but some people lower the bed and then transfer the resident from there. During an interview on [DATE], at 2:54 P.M. Licensed Practical Nurse (LPN) D said: -The resident needs assistance of two staff during transfers with a gait belt used. -Some staff aren't comfortable using the gait belt, so staff will use a mechanical lift. -The resident can bear weight during the transfer. -Generally, the resident can stand and pivot during the transfer with a gait belt. -The resident has not changed in his/her transfer ability in a while and can continue to bear weight. During an interview on [DATE], at 3:01 P.M., the Assistant Director of Nursing (ADON) said: -A Hoyer lift should be used if the resident is not bearing weight that day. -The resident's transfer ability changes day to day but has not changed overall since admission. -She reviewed the incident report for the fall in January 2020 and staff lowered the resident. She assumed staff lowered the resident because the resident had a day where he/she could not bear weight. Staff should be using a gait belt anytime and should have used a gait belt during the transfer in January 2020. During an interview on [DATE], at 3:12 P.M., the DON said: -He/she completed a one person transfer about two weeks ago with the resident and it was fine. -If the resident is cooperative and trying, then the resident is a easy one person transfer. -Otherwise, the resident needs a two person transfer but if the resident isn't bearing weight or not cooperative, then a Hoyer lift should be used. -He/she told the staff to use a Hoyer lift today as he/she thought the resident was not going to bear weight. The resident's mood is a day to day change. 2. During an interview on [DATE], at 2:54 P.M., LPN D said: -During a one person transfer, staff should put one hand on the resident's backside while holding the gait belt with the other hand. During a two person transfer, both staff have one hand on the gait belt and the other hand may help reposition the wheelchair. -Staff should not put their hands under the resident's arm pit. The resident's bed needs to be high enough or low enough to have the resident's feet securely flat on the floor for the transfer. - If two staff are lifting greater than 70 pounds during a transfer, then staff should use a Hoyer lift. If one staff is lifting more than 35 pounds during a transfer, staff should use a Hoyer lift. 3. During an interview on [DATE], at 3:01 P.M., the ADON said: -During a transfer, one staff's hand needs to be on the gait belt and the other hand needs to be used to steady the resident. -Staff's hands should never be underneath the armpits. This can cause damage. -The resident's feet should be able to touch the floor before the transfer. -If staff have to bear more than 35% of the resident's weight; then they should use a Hoyer lift, or sit to stand lift if the resident can follow commands. -If the resident cannot follow commands, staff should use a Hoyer lift. 4. During an interview on [DATE], at 3:12 P.M., the DON said: -During a transfer, staff should have one hand on the gait belt on the back or front and he/she would prefer staff to not lift the resident under the armpit. -If transferring a resident from the bed to a wheelchair, the bed needs to be at a comfortable level to where the resident can have feet flat on the floor. -If staff is lifting over 35 pounds of the resident's weight during a one person transfer, then they need to use a Hoyer lift or go to a two person transfer. -If during a two person transfer, staff are lifting over 70 pounds, staff should use a Hoyer lift.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide ongoing communication and/or documentation of communication with the [MEDICAL TREATMENT] (the cleaning of blood with a machine due to kidneys not working) center for one resident (Resident #6) who received [MEDICAL TREATMENT] out of a sample of 15 residents selected for review in a facility with a census of 30. Record review of the facility's policy titled, care of resident receiving [MEDICAL TREATMENT], dated January 2003, showed the following general documentation guidelines: -Frequency of documentation should follow the facility policy; -Staff should document any communication with the physician or the [MEDICAL TREATMENT] center; -Staff should document any unusual signs or symptoms; -Staff should document the frequency of [MEDICAL TREATMENT], shunt site, diet in the nursing summary documentation; -The policy did not address how often the facility should communicate with the [MEDICAL TREATMENT] center or a process to ensure ongoing communication occurred with the [MEDICAL TREATMENT] center. 1. Record review of Resident #6's face sheet (a general information sheet) showed the following information: -The resident admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's baseline care plan (in the I care plan format), dated 8/16/19, showed the following information: -Let me take care of my shunt (access site for [MEDICAL TREATMENT]) and catheter by myself, I'll tell you if I have a problem; -Have me ready early Monday and Friday to go to [MEDICAL TREATMENT]; -Give me medications the physician ordered to keep my blood levels ok; -Let me do my own pre-shunt care for [MEDICAL TREATMENT]; -The [MEDICAL TREATMENT] clinic schedules my transportation but call them if the driver doesn't show up to take me; -Don't ask me to look at my shunt when I get back from [MEDICAL TREATMENT], I know when to tell you if something is wrong; -Add 1 scoop of protein powder to my omelet every morning. Record review of the resident's nurses' notes showed the following information: -On [DATE], at 10:34 A.M., the social worker from the [MEDICAL TREATMENT] center called the facility and said transportation had been arranged for Resident #6 for Wednesday; -On 12/10/19, at 7:47 P.M., the resident admitted to the hospital with [REDACTED]. -On 12/10/19, at 9:35 P.M., the hospital called the facility with an update. The resident was on intravenous (IV) antibiotic (ABT) and had a flare up of [MEDICAL CONDITION] ([CONDITION]) in addition to the infection. Record review of the resident's medical record showed no [MEDICAL TREATMENT] communication form or documented communication at anytime between the facility and the [MEDICAL TREATMENT] center regarding the resident's hospital admission, [CONDITION] flareup, and infection requiring IV ABT treatment on 12/10/19. Record review of the nurses' notes showed the following information: -On [DATE], at 12:40 P.M., the resident returned to the facility. -On 12/13/19, at 11:13 A.M., the resident aroused to voice and light touch. The resident reported high blood pressure at the [MEDICAL TREATMENT] center this morning. Record review of the resident's medical record showed no [MEDICAL TREATMENT] communication form or documented communication between the facility and the [MEDICAL TREATMENT] center regarding the resident's change in condition on 12/13/19. Record review of the nurses' notes, dated 12/16/19, at 10:24 A.M., showed staff interviewed the resident for a significant change in status assessment. The resident had been hospitalized and returned to the facility for [DIAGNOSES REDACTED]. Record review of the resident's medical record showed no [MEDICAL TREATMENT] communication form or documented communication between the facility and the [MEDICAL TREATMENT] center in regards to the change of condition discussed on 12/16/19. Record review of the nurses' notes, dated 12/18/19, at 8:39 A.M., showed a late entry regarding plan of care (POC) meeting conducted on 12/17/19, in which the team discussed the resident's recent hospitalization for UTI and [MEDICAL CONDITION]. Record review of the resident's medical record showed no [MEDICAL TREATMENT] communication form or documented communication between the facility and the [MEDICAL TREATMENT] center in regards to the POC meeting. Record review of the resident's significant change Minimum Data Set (MDS), a comprehensive assessment instrument, completed by facility staff, dated 12/18/19, showed the resident as cognitively intact. Record review of the resident's nurses' notes, dated [DATE], at 4:37 A.M., showed staff administered [MEDICATION NAME] (medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	1505 MINER, PO BOX 248 SARCOXIE, MO 64862

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 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) used to prevent or treat nausea and vomiting) at 3:39 A.M. The resident said he/she would attend [MEDICAL TREATMENT] that morning. Record review of the resident's medical record showed no [MEDICAL TREATMENT] communication form or documented communication between the facility and the [MEDICAL TREATMENT] center regarding symptoms/concerns prompting the administration of the [MEDICATION NAME] medication on [DATE]. Record review of the resident's nurses' notes, dated 1/07/2020, at 2:44 P.M., showed the facility had a care plan meeting and discussed the resident's low [MEDICATION NAME] level (protein in the blood, if [MEDICATION NAME] level is good, fluid will move more easily from swollen tissues into the blood , where it can be removed by the dialyzer (machine used to purify the blood when kidneys are not working normally) and how to increase protein supplement. Record review of the resident's medical record showed no [MEDICAL TREATMENT] communication form or documented communication between the facility and the [MEDICAL TREATMENT] center regarding the resident's low [MEDICATION NAME] level or the plan to increase the resident's protein supplement as discussed on 1/7/2020 during the resident's care plan meeting. Record review of the nurses' notes showed the following information: -On 1/31/2020, at 12:03 P.M., the resident returned to the facility after [MEDICAL TREATMENT] with no change in status. The resident said he/she had a good day; -On [DATE], at 2:56 P.M., the facility received a call from the hospital. The hospital sent the resident back to the facility with a positive test result for Influenza A and returned on [DATE], at 5:50 P.M. Record review of the resident's medical record showed no [MEDICAL TREATMENT] communication form or documented communication between the facility and the [MEDICAL TREATMENT] center regarding the Influenza A [DIAGNOSES REDACTED]. During an interview on [DATE], at 12:17 P.M., Certified Nursing Assistant (CNA) C said the following: -He/she has helped Resident #6 prepare for [MEDICAL TREATMENT] in the morning times; -He/she would observe the resident put the medication on his/her arm before leaving for [MEDICAL TREATMENT]; -They would make sure Resident #6 had lunch, drain the catheter bag, get phone and tablet and help with putting shoes on the resident; -He/she has never given a communication sheet to the resident for [MEDICAL TREATMENT] communication and doesn't know about a communication sheet; -The resident will stop by the nurse's station to check and doesn't know if the resident gets a communication sheet from the nurses; -He/she hasn't worked with the resident when he/she returns from [MEDICAL TREATMENT]. During an interview on [DATE], at 1:07 P.M., CNA B said the following: -He/she has worked with Resident #6 when he/she comes back from [MEDICAL TREATMENT]; -Resident #6 is taken to his/her room when he/she returns from [MEDICAL TREATMENT] and put into her his/her recliner after clothes are changed; -There is no paperwork that is returned with the resident that CNA B knows about; -CNA B does not contact the [MEDICAL TREATMENT] center, it would be nurses or the social worker; -Nurses will talk to the resident and call the [MEDICAL TREATMENT] center is there are problems or pain; -CNAs will watch for shaking or lethargy due to low blood glucose levels and will watch for clamminess or if they can't wake him/her due to high blood pressure; -The resident can tell staff if something is wrong and they don't check the [MEDICAL TREATMENT] site; -If there is redness, irritation, or bleeding at the site, he/she would tell a nurse. During an interview on [DATE], at 12:21 P.M., Licensed Practical Nurse, (LPN) D said the following: -Resident #6 doesn't take paperwork with him/her; -Once a month, the face sheet and medication list is faxed to the [MEDICAL TREATMENT] center; -If there are issues, the facility will speak with a specific [MEDICAL TREATMENT] nurse; -There is only communication when there are issues; -Resident #6 does his/her own aftercare, the facility doesn't monitor vital signs when he/she returns from [MEDICAL TREATMENT]; -If the resident misses Monday's [MEDICAL TREATMENT], they will reschedule for Wednesday. During an interview on [DATE], at 1:15 P.M., the Assistant Director of Nursing (ADON) said the following: -The expectations for staff is to get snacks and check vital signs on the resident. The resident is very particular on what he/she will let the facility complete; -Resident #6 will administer his/her own prep and staff will watch; -Staff will take vital signs when Resident #6 returns from [MEDICAL TREATMENT] due to his/her noon medication requires that; -The facility will send updated medication sheets weekly and [MEDICAL TREATMENT] will send new medication changes back with the resident; -If there are any concerns, the facility will call the [MEDICAL TREATMENT] center; -If there aren't concerns or new medication changes, they don't really communicate with the [MEDICAL TREATMENT] center; -Communication is geared around changes or concerns; -The facility did call about the flu and any updates, like going to the hospital. During an interview on 3/13/2020, at 9:30 A.M., the Director of Nursing (DON) said the following: -There has only been one other resident who has had [MEDICAL TREATMENT] and there was a communication sheet and staff know the protocol; -Resident #6 has been educated to tell staff is there are changes; -After the resident returns from [MEDICAL TREATMENT], the facility staff will assist the resident to his/her room and he/she is quite capable of telling staff what is going on; -The facility or the [MEDICAL TREATMENT] center will call each other if there are issues; -The facility will call and confirm new orders by the [MEDICAL TREATMENT] center; -If the resident can't tell the facility about issues, the facility would make a call to the [MEDICAL TREATMENT] center; -At one time, the facility had a [MEDICAL TREATMENT] form.
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 document and attempt to use alternatives prior to installing a side or bed rail, failed to complete resident specific assessments of residents for risk of entrapment from bed rails prior to installation and/or reassess routinely; failed to review the risks and benefits of bed rails with the resident or resident representative; and failed to obtain informed consent prior to installation of side rails for six residents (Resident #8, #9, #14, #18, #21, and #22) out of a sample of 15 residents with a census of 30. Record review of the guidance for industry and Food and Drug Administration (FDA) staff, Hospital Bed System Dimensional And Assessment Guidance To Reduce Entrapment, issued on [DATE]06, from the FDA, Center for Devices and Radiological Health, showed the following information: -The term medical bed and hospital bed are used interchangeably and include adult medical beds with side rails; -Evaluating the dimensional limits of the gaps in hospital beds may be one component of a bed safety program which includes a comprehensive plan for patient and bed assessment; -Bed safety programs may also include plans for reassessment of hospital bed systems; -Reassessment may be appropriate when there is reason to believe that some components are worn, such as rails wobble, rails have been damaged, mattresses are softer and could cause increased spaces within the bed system; when accessories such as mattress overlays or positioning poles are added or removed; when components in the bed system are changed or replaced, such as new bed rails or mattresses; -Bed rails are rigid bars that are attached to the bed and are available in a variety of sizes and configurations from full length to half, one-quarter, and one-eighth length and are used as restraints, reminders, or as assistive devices; -Zone 1 is the measurement within the rail, any open space within the perimeter of the rail, a loosened bar or rail can change the size of the space; -Zone 2 is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at a location between the rail supports or next to a side rail support. Factors to consider are the mattress compressibility which may change over time due to wear, the lateral shift of the mattress or rail, and any degree of play from loosened rails or rail supports. A restless patient may enlarge the space by compressing the mattress beyond the specified dimensional limit. This space may also change with different rail height positions and as the head or foot sections are raised or lowered; -Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head; -Zone 4 is the gap that forms between the mattresses compressed by the patient and the lowermost portion of the rail, at the end of the rail. Factors that may increase the gap size are mattress compressibility, lateral shift of the mattress or rail, and degree of play from loosened rails; -General testing considerations include for ease of mattress movement and measurement, and general safety, the patient should not be in the bed during the measurement procedures. Record review of the side (bed) rails policy, dated 1/2003 showed the following information: -General guidelines for assessment may include but are not limited to: ability to stand, transfer and ambulate independently, pain or discomfort, bowel and bladder control, ability to understand and make self understood, short or long term memory, change in level of consciousness, dehydration and fluid balance, change in behavior, ability to use call light, whether or not resident requests assistance when needed, safety judgement, vision impairment and resident's customary routine. -If the resident requests not to or refuses to have the side rails up on his/her bed, assess him/her for risk for falls and the need for side rails. -Explain risks and benefits. -If the resident is alert and able to ambulate safely alone by order of the attending physician, have the resident sign the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	1505 MINER, PO BOX 248 SARCOXIE, MO 64862

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 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) Release of Side Rails form, if required by facility policy, and place the form in the resident's medical record. -This form is not recommended for confused residents. 1. Record review of Resident #9's certified nurse assistant (CNA) care plan, dated 10/15/2019, showed the following information: -Required two staff and gait belt for transfers; -Keep resident's bed in low position unless staff are in the room. -Staff did not address the resident's side rail use. Record review of the resident's side rail screen, dated 12/30/2019, showed the following information: -Is the resident: -Non-ambulatory?- Yes; -Is aware of safety? -No; -Have a history of falls? - Yes; -Has poor bed mobility?- Yes; -Has poor balance?- Yes; -Using side rail support?- No; -Has requested side rails?- No; -Side rails needed for safety? -No; -Will side rails promote independence? - No; -Is further evaluation needed? - No; -Side rails needed?- No. Record review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 12/31/19, showed the following information: -Admission to the facility on [DATE]; -[DIAGNOSES REDACTED]. Record review of the resident's active full care plan, dated [DATE], showed the following information: -Resident did not move much and might develop sores on his/her skin; -Keep a biocore mattress (foam mattress) on the resident's bed; -The care plan did not address the resident's side rail use. Record review of the resident's medical record showed the following: -Staff did not complete or obtain any consent forms regarding side rails; -Staff did not document any review with the resident or the resident's representative about risks and benefits of side rails. -Staff did not document alternatives attempted prior to installation of the side rails. -Staff did not document gap assessments of the resident's risk of entrapment from the bed rails prior to installation or any reassessments of the resident's risk for entrapment. Observation on [DATE]20, at 8:45 A.M., showed the resident lay in bed. The resident's bed was positioned length-wise alongside the wall. The bed had two half siderails (upper and lower on the exposed side of the bed) attached to the bed frame in the lowered position. Observation on 3/11/2020, at 8:35 A.M., showed the resident lay in bed and the upper and lower half side rails of the exposed side of the bed were in the lowered position. Observation on 3/11/2020, at 3:08 P.M., showed the resident lay in bed and the upper and lower half side rails of the exposed side of the bed were in the lowered position. Observation on [DATE], at 9:35 A.M., showed the resident lay in bed with the upper side rail of the exposed side of the bed in the raised position. The lower half side rail on the exposed side of the bed was in the lowered position. Observation on [DATE], at 2:06 P.M., showed the resident shook the upper half side rail (in the raised position) on the exposed side of the bed. During an interview on [DATE], at 10:19 A.M., CNA G said when helping reposition the resident, the top half bed rail is in the raised position on both sides of the bed so the resident can help turn. But, if the resident is sleeping, he/she does not need side rails. When the resident is awake, staff keep the side rails up because he/she tries to climb out of the bed and that is why the floor mats are on the floor. The resident will shake the bed rails when wanting to get out of bed. The resident is able to sit up in bed on his/her own. During an interview on [DATE], at 11:20 A.M. and 12:50 P.M., the Director of Nursing (DON) said the resident uses a bed rail for turning and the bed is in a low position with a fall mat because he/she is a high risk for falls. The DON said he/she is unsure if other attempts had been documented first before trying side rails for the resident. The resident has used bed rails since the time of admission to the facility. She did not find any gap assessments or any other information about the resident's side rails. 2. Record review of Resident #21's CNA care plan, dated 11/19/2019, showed the following information: -Staff will remind the resident to stand slowly if the resident has been sitting a long time. -Staff will remind the resident to call staff if the resident is feeling weak or more shaky. -Staff will routinely come and help the resident get ready in the mornings as that is the time of day when the resident usually has falls. -Staff are to encourage the resident to reposition himself/ herself in bed. -The CNA care plan did not address the resident's side rail use. Record review of the resident's side rail screen, dated 2/4/2020, showed the following information: -Is the resident: -Non-ambulatory?- No -Is aware of safety? -Yes -Have a history of falls? - Yes -Has poor bed mobility?- No -Has poor balance?- Yes -Using side rail support?- Yes -Has requested side rails?- Yes -Side rails needed for safety? -No -Will side rails promote independence? - Yes -Is further evaluation needed? - No -Instructions:- rail up to promote bed mobility; -Side Rails needed: No Record review of the resident's quarterly MDS, dated [DATE], showed the following information: -Admission to the facility on [DATE]; -[DIAGNOSES REDACTED]. mat placed on the bed which will sound an alarm when movement is beyond set parameters)- not used; -Required limited assistance and one person physical assist for bed mobility, transfer, walk in room, walk in corridor, dressing, toilet use, and personal hygiene; -Required a wheelchair to move throughout the facility. Record review of the resident's full care plan, dated [DATE]20 showed the following information: -Encourage the resident to reposition his/ her self in bed. -Staff did not address the resident's side rail use. Record review of the resident's medical record showed the following information: -Staff did not complete or obtain any consent forms regarding side rails; -Staff did not document any review with the resident or the resident's representative about risks and benefits of side rails. -Staff did not document alternatives attempted prior to installation of the side rails. -Staff did not document gap assessments of the resident's risk of entrapment from the bed rails prior to installation or any reassessments of the resident's risk for entrapment. Observation on [DATE]20, at 8:46 A.M., showed the resident lay in bed on his/her back. The resident's bed was positioned where the head of the bed was against the wall while the foot of the bed was positioned away from the wall. The bed had two half siderails (upper and lower on both sides of the bed) attached to the bed frame. The upper side rails on both sides of the bed were in the raised position. The lower side rails were in the lowered position. Observation on 3/11/2020, at 2:57 P.M., showed the resident lay in bed on his/her back. The resident's bed was positioned where the head of the bed was against the wall while the foot of the bed was positioned away from the wall. The bed had two half siderails (upper and lower on both sides of the bed) attached to the bed frame. The upper side rails on both sides of the bed were in the raised position and the lower side rails were in the lowered position. Staff assisted the resident to reposition in bed. The resident did not grab or hold the side rail when staff turned him/her. During an interview on [DATE], at 10:19 A.M., CNA G said the resident's upper side rails are in the raised position all of the time because the resident uses the side rails to help him/her turn and also has a personal alarm so staff know when the resident is up. The resident forgets to call for help sometimes. The resident has always had the two upper and two lower side rails on his/her bed since admission. He/she does not think the facility tried any alternatives first before placing side rails on the bed. During an interview on [DATE], at 10:54 A.M., Licensed Practical Nurse (LPN) D said the resident usually has one or both upper side rails in the raised position on both sides of the bed and uses the side rails for positioning. The resident has used side rails since admission. During an interview on [DATE], at 11:20 A.M. and 12:50 P.M., the DON said the resident has had upper half side rails on his/her bed frame since admission. The resident felt safer with the upper half side rails in the raised position. She did not find any gap assessments or any other information about the resident's side rails. 3. Record review of Resident #8's face sheet (basic resident information sheet) showed the resident had [DIAGNOSES REDACTED]. Record review of the resident's CNA care plan, dated 10/10/19, showed the following information: -Resident used a walker and wheelchair; -Required two staff to help the resident stand and transfer to the wheelchair; -Staff did not address the resident's side rails in the care plan. Record review of the resident's active care plan, dated 10/10/19, showed the following information: -The resident needed help with everyday things; -Staff did not address the resident's side rails in the care plan. Record review of the resident's significant change MDS, dated [DATE], showed the following information: -Moderate cognitive impairment; -No behaviors; -Required extensive assistance of two staff for bed mobility, transfers, and toileting; -Incontinent of urine frequently. Record review of a side rails screen form, dated [DATE], showed the following information: -Is non-ambulatory?-No; -Is comatose?-No; -Is aware of safety? Yes; -Have a history of falls?-No; -Has poor bed mobility?-Yes; -Has poor balance?-Yes; -Has postural [MEDICAL CONDITION] (blood pressure drops when resident stands or sits up)?-No; -Precautions needed due to medications?-No; -Using side rail support?-Yes; -Has requested side rails?-Yes; -Side rails needed for safety?-No; -Will side rails promote independence?-Yes; -Is further evaluation needed?-No; -ADL (activities of daily living) Instructions: One-half rail at resident's request to improve bed mobility; -Side rails needed?-Yes. Record review of the resident's medical record showed the following: -Staff did not complete or obtain any consent forms regarding side rails; -Staff did not document any review with the resident or the resident's representative about risks and benefits of side rails. -Staff did not document alternatives attempted prior to installation of the side rails. -Staff did not document gap assessments of the resident's risk of entrapment from the bed rails prior to installation or any reassessments of the resident's risk for entrapment. Observation on 3/09/2020, at 11:18 A.M., showed the resident lay in bed. The resident's bed had three half-sized side rails with two on the upper half of each side of the bed, and one lower half-sized rail to the left lower side of the bed. All three side rails were in the raised position. Observation on 3/11/2020, at 10:50 A.M., showed the resident lay in bed on his/her right side. Both half-sized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	1505 MINER, PO BOX 248 SARCOXIE, MO 64862

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 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) side rails were in the raised position on the upper portion of the bed. The lower right half-sized side rail was in the down position. 4. Record review of Resident #14's face sheet showed the resident had [DIAGNOSES REDACTED]. Record review of the resident's CNA care plan, dated 7/23/19, showed the following information: -Used a walker and wheelchair; -It takes one person to help the resident stand and walk; -Staff did not address the resident's side rails in the care plan. Record review of the resident's active care plan, dated 1/9/2020, showed the following information: -fell a lot at home; -Stop and help resident if you see him/her getting up without assistance; -Keep the resident's bed in low position when staff not in his/her room; -Remind resident often to ask for assistance; -Staff did not address the resident's side rails in the care plan. Record review of a side rails screen form, dated [DATE]20, showed the following information: -Is non-ambulatory?-No; -Is comatose?-No; -Is aware of safety? No; -Have a history of falls?-Yes; -Has poor bed mobility?-Yes; -Has poor balance?-Yes; -Has postural [MEDICAL CONDITION]?-No; -Precautions needed due to medications?-No; -Using side rail support?-Yes; -Has requested side rails?-No; -Side rails needed for safety?-No; -Will side rails promote independence?-Yes; -Is further evaluation needed?-No; -ADL Instructions: One-half rail up to assist with bed mobility; -Side rails needed?-No. Record review of the resident's admission MDS, dated [DATE], showed the following information: -Severe cognitive impairment; -No behaviors; -Required supervision and set-up with bed mobility; -Required supervision by two staff for transfers; -Required extensive assistance of two staff for toileting. Record review of the resident's medical record showed the following information: -Staff did not complete or obtain any consent forms regarding side rails; -Staff did not document any review with the resident or the resident's representative about risks and benefits of side rails. -Staff did not document alternatives attempted prior to installation of the side rails. -Staff did not document gap assessments of the resident's risk of entrapment from the bed rails prior to installation or any reassessments of the resident's risk for entrapment. Observation on 3/09/2020, at 9:17 A.M., the resident sat on the left side of the bed. The half-sized side rail on the upper left side of the bed was in the raised position. The half-sized side rail on the left lower side of the bed was in the lowered position. Observation on 3/09/2020, at 11:28 A.M., showed the resident's bed had both left side upper and lower half-sized side rails in the lowered position. The resident was not in the room. Observation on 3/09/2020, at 1:22 P.M., the resident's bed had the left upper side rail in the raised position, and the lower half-sized bed rail on the left side in the lowered position. The resident was not in the room. Observation on 3/11/2020, at 10:53 A.M., showed the resident sat in a wheelchair in his/her room. The half-sized side rail on the left upper side of the bed was in the raised position. The left lower half-sized side rail was in the lowered position. 5. Record review of Resident #18's face sheet showed the resident had [DIAGNOSES REDACTED]. Record review of the resident's active care plan, dated 10/16/19, showed staff did not address the resident's side rails in the care plan. Record review of a side rails screen form, dated 1/20/2020, showed the following information: -Is non-ambulatory?-Yes; -Is comatose?-No; -Is aware of safety?-No; -Have a history of falls?-No; -Has poor bed mobility?-Yes; -Has poor balance?-Yes; -Has postural [MEDICAL CONDITION]?-No; -Precautions needed due to medications?-No; -Using side rail support?-No; -Has requested side rails?-No; -Side rails needed for safety?-Yes; -Will side rails promote independence?-No; -Is further evaluation needed?-No; -ADL Instructions: One-half rail; -Side rails needed?-No. Record review of the CNA care plan, dated [DATE], showed the following information: -The resident was blind; -Used other operated wheelchair; -Reposition resident from side to side; -Use a mechanical lift and two staff to transfer the resident; -Staff did not address the resident's side rails in the care plan. Record review of the resident's quarterly MDS, dated [DATE], showed the following information: -Severe cognitive impairment; -Resident had hallucinations; -Total dependence on staff for bed mobility, transfers, toileting, and eating. -The resident did not walk. Record review of the resident's medical record showed the following information: -Staff did not complete or obtain any consent forms regarding side rails; -Staff did not document any review with the resident or the resident's representative about risks and benefits of side rails. -Staff did not document alternatives attempted prior to installation of the side rails. -Staff did not document gap assessments of the resident's risk of entrapment from the bed rails prior to installation or any reassessments of the resident's risk for entrapment. Observation on [DATE]20, at 9:14 A.M., showed the resident lay in bed. The resident's bed had two upper half-sized rails and one bottom half-sized side rail on the left side of the bed in the raised position. Observation on [DATE]20, at 1:12 P.M., showed the resident lay in bed on his/her left side. The resident's bed had two upper half-sized rails in the raised position, and one bottom half-sized side rail on the left side of the bed in the lowered position. Observation on 3/11/2020, at 10:42 A.M., showed the resident lay in bed on his/her right side. Both half-sized side rails on the right upper and lower side of the bed were in the lowered position. The upper half-sized side rail on the left side of the bed against the wall was in the raised position. Observation on 3/11/2020, at 10:49 A.M., showed the resident lay on his/her back in bed. Both half-sized side rails on the right upper and lower side of the bed were in the raised position. The upper half-sized side rail on the left side of the bed against the wall was in the raised position. 6. Record review of Resident #22's face sheet showed the resident had [DIAGNOSES REDACTED]. Record review of the CNA care plan, dated 1/[DATE]9, showed the following information: -Check on the resident every two hours while in bed and assist the resident if he/she tries to get out of bed; -Have one person stand by while the resident transfers; -Tell the nurse if the resident is hurting; -Staff did not address the resident's side rails in the care plan. Record review of the resident's active full care plan, dated 11/15/19, showed the following information: -The resident had falls since at the facility. Put a bed alarm on the bed so staff will know when the resident tries to get up alone; -Staff did not address the resident's side rails in the care plan. Record review of a side rails screen form, dated 2/4/2020, showed the following information: -Is non-ambulatory?-No; -Is comatose?-No; -Is aware of safety? No; -Have a history of falls?-Yes; -Has poor bed mobility?-Yes; -Has poor balance?-Yes; -Has postural [MEDICAL CONDITION]?-No; -Precautions needed due to medications?-No; -Using side rail support?-Yes; -Has requested side rails?-Yes; -Side rails needed for safety?-No; -Will side rails promote independence?-Yes; -Is further evaluation needed?-No; -ADL Instructions: One-half rail up to assist with bed mobility and transfer; -Side rails needed?-No. Record review of the resident's significant change MDS, dated [DATE], showed the following information: -Severe cognitive impairment; -Required extensive assistance of two staff for bed mobility, transfers, and toileting. Record review of the resident's medical record showed the following information: -Staff did not complete or obtain any consent forms regarding side rails; -Staff did not document any review with the resident or the resident's representative about risks and benefits of side rails. -Staff did not document alternatives attempted prior to installation of the side rails. -Staff did not document gap assessments of the resident's risk of entrapment from the bed rails prior to installation or any reassessments of the resident's risk for entrapment. Observation on [DATE]20, at 9:12 A.M., showed the resident lay in bed. The bed had two half-sized upper side rails in the raised position, and two half-sized lower side rails in the down position. Observation on [DATE]20, at 1:08 P.M., showed the resident lay in bed. The bed had both half-sized side rails in the raised position on the upper part of the bed, and one half-sized side rail in the raised position on the left side of the bed against the wall. The half-sized side rail on the right side of the bed was in the lowered position. Observation on [DATE]20, at 2:40 P.M., showed the resident lay in bed with the two half-sized side rails on the upper part of the bed in the raised position. The half-sized side rail on left lower side of the bed was in the lowered position. Observation on 3/11/2020, at 10:51 A.M., showed the resident lay in bed on his/her left side. The bed had two half-sized side rails and the lower right side half-sized side rail was in the raised position. The half-sized side rail on the left lower side of the bed was in the lowered position. 7. During an interview on [DATE], at 10:19 A.M., CNA G said the bed frames can have side rails removed but all bed frames start with the side rails attached to them. Side rails are in the down position when a resident is admitted to the facility unless the resident has a physician's orders [REDACTED]. If the resident does not need side rails, then the side rails come off of the bed frame. The nurses complete an assessment to determine fall risk and leave the side rails on the bed frame just in case until the facility knows the resident will not climb out or roll out of bed. If a resident climbs out of bed, the two upper and the two lower rails will be put in the raised position and staff will put cushions on the floor. 8. During an interview on [DATE], at 10:40 A.M., CNA C said the beds come with four half side rails already attached to the bed frame and that nurses assess if the residents need side rails or if the resident requests the side rails. If staff is not sure whether or not a resident needs side rails, staff can look on the CNA care plan or can look on the active full care plan. 9. During an interview on [DATE], at 10:53 A.M., LPN D said the beds come with all four side rails attached to the bed frame. If the residents are capable to tell staff to leave rails up, then staff will leave side rails on. If a resident cannot communicate to staff that the resident wants the side rails in the down position, then staff will remove the side rails because side rails would be considered a restraint at that point. If the resident has an air mattress, then side rails are recommended. The DON does the side rail and gap assessments yearly for each resident with side rails. RN D said he/she does not think the facility has consent forms on side rails. The facility has families that are adamant and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265649	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SARCOXIE NURSING CENTER	**1505 MINER, PO BOX 248 SARCOXIE, MO 64862**

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 0700 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) will get a physician order [REDACTED]. 10. During an interview on [DATE], at 11:20 A.M., the DON said the beds come with side rails and when someone is admitted the side rails are attached to the bed. The resident is assessed for cognitive ability, transfer ability, if the resident requests them, if the rails assist them with bed mobility, and if it is an air mattress, then all four rails are used and placed in the raised position. The DON will type what the side rail plan is in the ADL section of the electronic record. The previous MDS Coordinator left the facility six months ago; but, it was his/her role to complete the assessments quarterly. The DON discovered that the MDS Coordinator had not completed these assessments quarterly. The DON then began completing the assessments in the last month or so. The DON uses the Primeris form for guidance for measurements, but she does not write down the measurements. He/she writes if the measurements pass or fail on the assessment. The alternatives attempted before putting up side rails are: low beds, fall mats, and bed alarms. Usually, if residents are alert and oriented, the facility allows residents to make the decision on whether or not side rails are used. The facility does not necessarily try alternatives first before placing side rails on the beds. Years ago, the DON completed consents for side rails. However, once the previous MDS coordinator began doing quarterly MDS assessments, the DON did not know for sure if the MDS coordinator completed consent forms for side rails. Side rail information is located in CNA care plans but not in the full care plans