STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265730	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EASTVIEW MANOR CARE CENTER	1622 EAST 28TH STREET TRENTON, MO 64683

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff treated residents with dignity and respect and to care for residents in a manner that promotes maintenance or enhancement of his/her quality of life when staff did not pull the privacy curtain and left one of 21 sampled residents (Resident #37) exposed while providing incontinent care while his/her roommate remained in the room in their bed facing the resident; staff failed to provided perineal care in dignified manner for one resident (Resident #45); and failed to provide personal grooming for two residents (Resident #5 and #14). The facility census was 82. 1. Review of the facility's Resident's Rights Policy, dated 3/22/17, showed: - Resident's have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. - Staff should protect and promote the rights of each resident. 2. Review of Resident #37's quarterly Minimum Data Set (MDS), a federally mandated assessment completed 1/13/20, showed: - Unable to conduct mental status interview. - Extensive assist on one staff for activities of daily living (ADLs). - [DIAGNOSES REDACTED]. Review of the care plan, dated 1/2/20, showed: - Problem: heart failure resulting in ADL assistance; - Approaches: staff assist with all ADLs such as personal care, dressing, brushing teeth, or cleaning dentures. Observation on 3/11/20, at 10:26 A.M., Certified Nurse Aide (CNA) B and CNA C entered the resident's room to provide perineal care and did the following: - CNA B and CNA C applied a gait belt and transferred the resident to his/her wheelchair; - Resident taken to the bathroom in his/he room; - CNA B pulled the resident's brief down and both CNAs assisted the resident to the commode; - The CNAs stood with the bathroom door open and curtain opened while the resident used the restroom; - CNA B performed perineal care for resident, applied brief, and clothing; - The resident's roommate was in his/her bed facing the bathroom without the curtain or bathroom door closed. During an interview on 3/12/20, at 5:05 P.M., CNA C said: - Staff should provide privacy during personal care and he/she should have pulled the privacy curtain prior to assisting the resident in the restroom. 3. Review of Resident #45's significant change in condition MDS, dated [DATE], showed: - Severe cognitive impairment; - Extensive assist of one staff for toilet and personal care; - Indwelling catheter (tube inserted into the bladder to drain urine); - Incontinent of bowel; - [DIAGNOSES REDACTED]. Review of the care plan, updated on 1/21/20, showed: - Problem: Foley catheter and need assistance to go to the bathroom for bowel movement. - Approach: assist with all ADLs. Observation on 3/11/20, at 10:24 A.M., showed CNA D, CNA E and CNA C provide catheter care in the following manner: - CNA D cleansed the resident's abdomen, groin, and skin folds with wipes, removing fecal material with each wipe. - CNA D removed his/her gloves and washed his/her hands while the resident lay exposed and not covered up; - CNA D cleansed the catheter and skin from insertion site and ran out of wipes; - CNA E left the room to get more supplies; - CNA D continued to hold the resident's genitals without covering the resident for several minutes while other aides were in the room; - Upon CNA E's return with supplies, CNA D completed perineal care; - CNA D removed his/her gloves and washed his/her hands while the resident lay exposed and not covered up; - CNA D and CNA C covered the resident and repositioned in bed. During an interview on 3/12/20, at 3:18 P.M., CNA D said: - He/she should have covered the resident when removing his/her gloves and washing his/her hands to provide dignity. - He/she should have released the resident's genitals and covered him/her up while waiting for supplies. 4. Review of Resident #5's quarterly MDS, dated [DATE], showed: - Severe cognitive impairment; - Extensive assistance on one staff for ADLs; - Incontinent of bladder; - [DIAGNOSES REDACTED]. Review of the resident's care plan, dated 1/1/20, showed: - Problem: requires assistance with ADLs due to pain and weakness; - Approaches: assist with showers per schedule, assist with daily hygiene and grooming tasks as she requests. Observation on [DATE] at 10:00 A.M., and [DATE] at 9:20 A.M., showed the resident had chin hairs with several days of growth. During an interview on 3/12/20, at 5:05 P.M., CNA C said: - Residents facial hair should be shaved or plucked daily. 5. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated, 12/11/19, showed: - Cognitive skills intact; - Independent with dressing, personal hygiene and bathing; - [DIAGNOSES REDACTED]. Review of the resident's care plan, dated 1/2/20, showed: - The resident was independent with ADLs, but required supervision due to his/her mental illness; - He/she liked to use shave cream and a razor to remove facial hair; - The resident refused to have facial hair removed most of the time. Observation and interview on [DATE], at 9:25 A.M., showed: - The resident had chin whiskers; - The resident said he/she had hormonal chin hairs and did not like them; - He/she would like to have them shaved on Tuesday and Saturday because he/she went to church on Wednesday and Saturday; - The resident said the staff act like it is not necessary; - It was embarrassing to have the chin hairs and he/she did not like it. Observation and interview on [DATE], at 9:26 A.M., showed: - The resident said the staff still had not shaved his/her hormonal whiskers; - He/she had asked but was still waiting. During an interview on 3/12/20, at 1:30 P.M., Licensed Practical Nurse (LPN) A said: - When the resident asked to be shaved, the staff tried to get it done as soon as possible. During an interview on 3/12/20, at 5:14 P.M., the Director of Nursing (DON) said: - Staff should make sure they shave the resident's chin whiskers when they want and check them daily and shave or tweeze as needed. - Staff should provide dignity and privacy when providing perineal care.
F 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure residents have reasonable access to and privacy in their use of communication methods.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with reasonable access to a telephone and privacy for phone conversations when one of 21 sampled residents (Resident #29) when the resident was observed at the nurses' station making a personal phone call; this also affected seven out of seven resident council members. The facility census was 82. Review of the facility's Resident's Rights Policy, dated 3/22/17, showed: - Residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. - Residents have the right to reasonable access to the use of a telephone where calls can be made without being overheard. Review of Resident #29's annual Minimum Data Set (MDS), a federally mandated assessment completed by facility staff, dated 1/3/20, showed: - Cognitive intact; - Independent with all activities of daily living (ADLs) - [DIAGNOSES REDACTED]. Observation on [DATE], at 1:00 P.M., at the nurses' station showed: - Resident #29 standing at the

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 0576 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) nurses' station talking on the telephone; - Multiple staff and residents walking in the common area, nurses station, and hallways; - He/she had one hand on the phone receiver and the other hand over his/her ear due to the noise level and unable to hear the other person on the telephone; - He/she was overhead talking about personal information. During an interview on [DATE], at 10:30 A.M., Resident #29 said: - He/she is unable to make private phone calls; - The phone available to him/her is standing at the nurses' station; - There no longer is a phone for residents in the hallway cubby to make phone calls; - He/she would like to be able to make phone calls without everyone hearing his/her conversations. During a resident group meeting on [DATE], at 11:00 A.M., showed: - Residents have to make phone calls at the nurses' station; - There is no privacy to make personal phone calls; - There no longer is a phone for residents in the hallway to make private phone calls; - Seven of seven residents said they would like a private location to talk on the telephone. Observation on [DATE], at 3:35 P.M., at the nurses' station showed: - Resident #29 standing at the nurses' station talking on the telephone; - He/she was overhead talking about personal information; - Multiple residents were standing near and around the nurses' station during his/her phone conversation. During an interview on 3/12/20, at 11:15 A.M., the Director of Nursing said: - Resident should have access to a telephone and privacy. - There should be a place in the hallway for residents to talk on the phone privately. - She was unaware the phone in the hallway cubby did not have a telephone receiver to make calls.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, the facility failed to assure staff kept residents' personal money protected from loss or theft, which affected two of 21 sampled residents (Resident #24 and #51). The facility failed to maintain a clean, comfortable and homelike environment when the staff failed to maintain floors free of a dirty wax build up, stained, dirt and grime on the floors throughout the facility and failed to provide each resident with a towel and wash cloth and failed to provide enough towels and wash cloths for residents who wanted a shower, which affected the residents who lived on the secured unit. The facility census was 82. Review of the facility's Housekeeping/Laundry Policy, dated 12/20/20, showed: - Deep cleaning is to be completed as scheduled. - Deep cleaning consists of complete pull-outs of furniture in rooms, wall cleaning, floor cleaning (scrubbing and waxing included), restrooms to be cleaned and disinfected, cobwebs removed, beds and rails to be cleaned, sprinkler heads to be cleaned, light covers to be clean and free of bugs, over-bed light covers to be cleaned and free of bugs, sink clean, windows to be cleaned and ensure no spider webs, drapes and curtains to be cleaned (including privacy curtains), call lights to be clean and free from dust/dirt build-up, floors at closets and doorways are to be fre from wax/dirt build up, etc. - All areas should be monitored on a daily basis and all resident living areas and non-living areas should be clean and odor free. - Daily cleaning consists of: trash removal; dust mop or sweep floor; submerge sponge with cleaning solution and clean surfaces beginning with a touch areas on door; surfaces are to be cleaned including wall smudges, light and call light, side tables, head and foot board, side rails of beds, and windows; clean the sink around the light fixtures and dispensers; clean inside and outside the trash can; clean bathroom; clean shower room. Review of the facility's Hotspot List, updated on 9/5/19, showed: - These bed should be washed every morning room [ROOM NUMBER]B, 2B, 4B, 5, 8A, 8B, 10A, 10B, 11A, 12B, 20B, 22A, 22B, and 27B. - These beds should be left stripped so housekeeping can wash them before remade. The facility did not provide a policy for providing towels and wash cloths. 1. Observation on [DATE], at 1:54 P.M., showed: - There was only one room on the secured unit with a towel and wash cloth. During a group interview on [DATE], at 3:20 P.M., on the unit, the residents said: - They did not have enough towels and wash cloths; - The majority of the time the residents had to wait for clean towels and wash cloths to be brought up from laundry before they could take their showers. During an observation and interview on 3/11/20, at 8:28 A.M., Certified Nurse Aide (CNA) A said: - There were 38 residents living on the secured unit; - Linens are brought up at least one to two times a shift and more if needed; - Normally the residents have towels and wash cloths in their rooms but honestly, the facility had been short on linens for months and the staff have not been able to pass them out; - Have had problems having enough staff in the laundry department which is another reason why there's not enough linens for the residents; - The linen cart on the secured unit had 8 wash cloths, 23 white towels and five colored towels. During an interview on 3/12/20, at 5:14 P.M., the Director of Nursing (DON) said: - The residents should have wash cloths and towels in their rooms; - Not for sure if laundry staff were not getting them done in a timely manner or if they needed to order more towels and wash cloths. 2. Observation and interview on [DATE], at 10:24 A.M., of the South medication cart showed: - Resident #24 had an envelope with his/her name on it; - Certified Medication Technician (CMT) A opened the envelope and it had $2.25 in it; - CMT A opened another envelope with Resident #51's name on it and it had $2.00 in it; - CMT A said the money is kept in the medication cart in case the resident wanted something from the vending machine. During an interview on 3/12/20, at 5:14 P.M., the Director of Nursing (DON) said: - The staff should not keep residents' money in envelopes in the medication cart; - The money should be placed in the safe by Social Services or on their person. 3. Observation on [DATE], showed the following: - room [ROOM NUMBER] at 9:00 A.M., the floor had ground in dirt and grime and looked like glue was coming up between the floor tiles; - room [ROOM NUMBER] at 10:16 A.M., the floor had multiple black marks on it with a large buildup of grime and dirt around the floor vents and around the doorframes; - room [ROOM NUMBER] at 12:43 P.M., the floor had black marks across 12 tiles; was dull and had a large buildup of grime and dirt around the doorframes and corners. Observations on [DATE] starting at 8:30 A.M., and all days of the survey, [DATE] through 3/12/20, showed the following: - All hallway floors in the facility to be dirty, black marks, sticky in areas, grime, tissues, and visible debris; - Dining room to have visible foot particles, black marks, sticky under tables, grime and dirty; - Multiple floors and bathrooms stained, dirty, and had grime; discolored grout around tiles and bathroom; black non-skid strips coming up off floors; floor heat vents dusty and show visible dirt; dried liquid; dirt and grime came up off several resident room floors with a wet paper towel. (Examples of rooms included: 2, 5, 8, 11, 12,16,17, 20, 29, 31, 36, 41 and 43; these same issues could be seen throughout the facility); - room [ROOM NUMBER] with a strong urine odor from the mattress; - The shower room on the West unit hall with scuff marks on walls, grime and dirt around the tub and tiles; no drain cover; - The unit dining room had dirt, black scuff marks, and discolored flooring; dried liquid on the wall under the temperature gauge; - The unit smoke room had copious amounts of dirt and grime on the floors with multiple discolored areas; coffee and beverages spilt down the sink, soap dispenser, walls and trash can; - The geriatric shower room with dirt, grime, and dried liquid on the floor, and fecal material splattered on the toilet. During an interview on 3/12/20, at 6:40 P.M., the maintenance director said: - The housekeeping/laundry supervisor resigned on [DATE]. - He/she is unsure of the current cleaning schedule. - Staff should clean rooms daily, hallways, bathrooms, showers, and hotspot rooms according to facility policy. - The dining room should be swept and mopped after every meal. - There is currently no staff or schedule for the floors to be cleaned and buffed regularly.
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 observation, interview, and record review, the facility failed to ensure staff provided a written notice of transfer or discharge to residents or their responsible parities and the reason for the transfer, in writing and in a language they understand when staff transferred two of 21 sampled residents (Resident #45 and #61). The facility census was 82. 1. Review of the facility's Resident Transfer/Discharge, Immediate Discharge, and Therapeutic Leave Policy, dated 5/28/20, showed: - Before any resident is transferred or discharged under a facility-initiated transfer or discharge the facility must notify the resident and the resident representative the reason for the transfer or discharge in writing in a

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F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) manner they understand. 2. Review of Resident #45's significant change in condition MDS, dated [DATE], showed: - Severe cognitive impairment; - Extensive assist of one staff for toilet and personal care; - Indwelling catheter (tube inserted into the bladder to drain urine); - Incontinent of bowel; - [DIAGNOSES REDACTED]. Review of the nurse progress note, dated 2/14/20, at 11:36 A.M., showed: - Resident having large amount of vomit; - Resident noted to have 104.5 degree Fahrenheit temperature and as needed [MED] given; - Physician notified and ordered to send to emergency department (ED) for evaluation. Review of the hospital ED physician report, dated 2/14/20, showed: - Resident presents with fever and vomiting; - Resident admitted to hospital for urinary tract infection [MEDICAL CONDITION]. Review of the nurse progress note, dated 2/25/20, showed: - readmitted to the facility from the hospital. Review of the resident's medical record on [DATE], showed: - The resident readmitted to the facility on [DATE], after a 10 day hospital stay. - The record showed no letter of reason for transfer/discharge to the hospital sent to the responsible party. 3. Review of Resident #61's annual MDS, dated [DATE], showed: - Cognitive intact; - Extensive assistance of two staff for all activities of daily living (ADLs); - Impaired bilateral upper and lower extremities; - [DIAGNOSES REDACTED]. Review of the nurses' notes showed: - 1/3/20, on day shift: Resident concerned of possible pneumonia; 99.4 degree Fahrenheit; bilateral non-productive cough with moist [MEDICATION NAME] sounds; physician notified and orders received for chest x-ray, influenza swab, and lab work; chest x-ray and influenza swab negative; urinalysis indicates UTI and antibiotics started; - 1/6/20, at 3:26 A.M.: Resident using accessory muscles to breath with respirations 22, 97.6 degree Fahrenheit, pulse 82, blood pressure 94/63, and [MED]gen at 85%; lungs with course crackles in all lung fields; physician notified and orders received for medications and [MED]gen therapy; - 1/8/20, at 1:21 P.M.: Resident complains of shortness of air; lungs diminished with wheezing; 100.4 degree Fahrenheit, 89% [MED]gen level with 3 liters of [MED]gen; physician notified and orders received to send resident to ED; -1/9/20, at 8:34 A.M.: Resident admitted to the hospital with [REDACTED]. Review of the nursing progress note, 1/12/20, at 5:43 P.M., showed: - readmitted to the facility from the hospital. Review of the resident's medical record on 3/12/20, showed: - The resident readmitted to the facility on [DATE], after a 4 day hospital stay; - The record showed no letter of reason for transfer/discharge to the hospital sent to the responsible party. 4. During an interview on 3/12/20, at 1:00 P.M.,. the Social Service Designee said: - He/she did not know a letter needed to be sent to the resident or responsible party when discharged or transferred to the hospital. During an interview on 3/12/20, at 5:14 P.M., the Director of Nursing (DON) said: - Staff should follow facility policy. - She did not know a letter needed to be sent to the resident or responsible party with each discharge/transfer to the hospital.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure staff maintained a medication error rate of less than five percent (%). Staff made four medication errors out of 25 possible opportunites for errors with an error rate of 16%. These errors affected four of 21 sampled residents (Resident #10, #25, #34, and #51). The facility census was 82. 1. Review of the facility's medication administration and monitoring policy, reaffirmed 4/6/17, showed in part: - The purpose is to ensure a process is in place for proper administration of medications, techniques of administering medications, techniques of administering medications, effective monitoring of residents for adverse consequences associated with side effects to medications; - The nurse or certified medication technician (CMT) will check each medication to the Medication Administration Record [REDACTED]. 2. Review of Resident #10's physician order [REDACTED]. Observation on [DATE] at 9:03 A.M., showed: - CMT A placed one gas relief 80 mg the medication cup and administered it to the resident. During an interview on 3/12/20 at 1:45 P.M., CMT A said: - He/she should clarify the order for the [MEDICATION NAME]. During an interview on 3/12/20, at 5:14 P.M., the Director of Nursing (DON) said: - Staff should have clarified the order for the [MEDICATION NAME]. 3. The facility did not have a policy for administration of nasal sprays. Review of the manufacturer's guidelines for [MEDICATION NAME] nasal spray (used to treat seasonal allergies [REDACTED]. Tilt your head forward slightly and keeping the bottle upright, carefully insert the nasal applicator into the other nostril; - Start to breathe in through your nose, and while breathing in press firmly and quickly down once on the applicator to release the spray; - Repeat in the other nostril. Review of Resident #25's POS, dated March, 2020, showed: - an order for [REDACTED].M., showed CMT A did the following: - Offered the resident a Kleenex to blow his/her nose and the resident declined; - The resident took the bottle of nasal spray, did not hold one side of his/her nostril closed and administered one spray to each nostril; - CMT A reminded the resident he/she needed another spray to each nostril; - The resident shook the bottle of nasal spray, did not hold one side of his/her nostril closed and administered one spray to each nostril; - CMT A did not give the resident any instructions on how to administer the nasal spray. During an interview on 3/12/20, at 1:45 P.M., CMT A said: - He/she should have followed the manufacturer's guidelines for administration of the nasal spray; - He/she should have given the resident instructions on how to use the nasal spray. During an interview on 3/12/20 at 5:14 P.M., the DON said: - The facility did not have a policy for the nasal spray; - Staff should follow the manufacturer's guidelines for administering nasal spray. 4. Review of the facility's blood glucose monitoring policy, reaffirmed 4/6/17, showed in part: - The purpose is to define accurate procedures to be followed when checking a blood sugar; - The policy did not address the use of [MED] pens. Review of Resident #34's POS, dated March, 2020, showed: - an order for [REDACTED]. Observation on 3/11/20, at 8:36 A.M., showed;- Licensed Practical Nurse (LPN) A did not clean the port of the [MED] [MED] pen and attached the needle; - LPN A dialed the [MED] pen to 12 and administered it to the resident; - LPN A did not prime the [MED] pen with two units of [MED]. During an interview on 3/12/20, at 1:30 P.M., LPN A said: - He/she forgot to clean the port with an alcohol wipe; - He/she should have primed the [MED] pen with two units before administering it to the resident. During an interview on 3/12/20, at 5:14 P.M., the DON said: - Staff should clean the port with an alcohol wipe before attaching the needle; - Staff should prime the [MED] pen with two units. 5. Review of the facility's administration of eye drop policy, reaffirmed 4/6/17, showed in part: - The purpose is to administer eye drops as prescribed by the attending physician; - With a gloved finger, gently pull down lower eyelid to form a pouch while instructing the resident to look up; - Hold the inverted medication bottle in free gloved hand and press gently to instill the prescribed number of drops into the pouch near the outer corner of the eye; - Do not let the top of the dropper touch the eye or any other surface; - Instruct the resident to close their eyes slowly to allow for even distribution over the surface of the eye; - The resident should not blink or squeeze their eye shut; - While the eye is closed, use a gloved finger to compress the tear duct near the inner lacrimal sac of the eye for one to two minutes. Review of Resident #51's POS, dated March, 2020, showed: - an order for [REDACTED]. Observation on 3/11/20, at 9:57 A.M., showed: - CMT A pulled the resident's lower right eyelid down and placed a drop into the outside corner of the resident's eye; - The resident took a Kleenex and wiped his/her eye; - CMT A pulled the resident's lower left eyelid down and placed a drop into the outside corner of the resident's eye; - The resident used the same Kleenex and wiped back and forth across both of his/her eyes; - CMT A did not apply lacrimal pressure. During an interview on 3/12/20, at 1:45 P.M., CMT A said: - He/she should have applied lacrimal pressure for one minute. During an interview on 3/12/20, at 5:14 P.M., the DON said: - Staff should apply lacrimal pressure for one minute.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff provided a safe and effective medication administration system that was free of significant medication errors when staff failed to prime an [MED] pen prior to administering [MED] which affected one of 21 sampled residents (Resident #34). The facility census was 82. 1. Review of the facility's medication administration and monitoring policy, reaffirmed 4/6/17, showed, in part: - The purpose is to ensure a process is in place for proper administration of medications, techniques of administering medications, techniques of administering medications, effective monitoring of residents for adverse consequences associated with side effects to medications. Review of the facility's blood glucose monitoring policy, reaffirmed 4/6/17, showed, in part: - The purpose is to define accurate procedures to be followed when checking a blood sugar; - The policy did not address the use of [MED] pens. 2. Review of Resident #34's physician order [REDACTED].M., showed; - Licensed Practical Nurse (LPN) A did not clean the port of the [MED] [MED] pen and attached the needle; - LPN A dialed the [MED] pen to 12 and administered it to the resident; - LPN A did not prime the [MED] pen with two units of [MED]. During an interview on 3/12/20, at 1:30 P.M., LPN A said: - He/she forgot to clean the port with an alcohol wipe; - He/she should have primed the [MED] pen with two units before administering it to the resident. During an interview on 3/12/20, at 5:14 P.M., the Director of Nursing (DON) said: - Staff should clean the port with an alcohol wipe before attaching the needle; - Staff should prime the [MED] pen with two units.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3)
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure there were no loose pills in the medication cart; failed to ensure staff removed kimvent suction swabs (used to remove oral debris and secretions) from the medication cart; failed to discard expired inhalers for one of 21 sampled residents (Resident #38) and one additional resident (Resident #52); and failed to ensure staff properly stored controlled substances (substances with a high probability for physical and/or psychological dependence for two residents (Residents #38 and #64). The facility census was 82. 1. The facility did not provide a policy. 2. Observation and interview on [DATE], at 10:24 A.M., of the unit two South medication room showed: - Half of a white oval pill loose in the drawer of the medication cart; - Certified Medication Technician (CMT) A said there shouldn't be any loose pills in the drawer, it should be destroyed. Observation and interview on 10:34 A.M., of the unit two South medication room, showed: - Two Kimvent suction swab kits, expired 8/2017; - CMT A said staff should not use anything that's expired, it should be destroyed. The medication room was checked weekly by Licensed Practical Nurse (LPN) A and he/she checked the medication cart twice weekly. 3. Review of the [MEDICATION NAME] inhaler (prevents respiratory symptoms) package insert, dated 1/2019, showed to discard the inhaler in one month after the foil pouch is opened. Observation on 3/11/20, at 10:50 A.M. of CMT B checking the medication cart and interview showed: - Resident #38's [MEDICATION NAME] inhaler opened 12/18/20; - Resident #52's [MEDICATION NAME] inhaler opened 12/18/20; - Both residents had gone to hospital and when they returned they were using the [MEDICATION NAME] inhalers prior to discharge; - [MEDICATION NAME] inhalers are good until manufactures expiration. Observation on 3/11/20, at 11:00 A.M., of CMT B checking the controlled substances on the medication cart and interview showed: - Resident #38's bubble pack [MEDICATION NAME] (treats anxiety and [MEDICAL CONDITION]) with a blister torn with a pill taped inside; - Resident #64's bubble pack [MEDICATION NAME] (treats anxiety and [MEDICAL CONDITION]) with a blister torn with a pill taped inside; - Staff should never tape medication back into blister packs; the medication should be destroyed according to facility policy. During an interview on 3/12/20, at 5:14 P.M., the Director of Nursing (DON) said: - Staff should not use expired medications. - Staff should destroy expired mediations. - Loose pills should not be in the medication cart. - Staff should always discard any controlled substances behind torn bubbles. - Staff should follow manufacture guidelines.