STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285303	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOSEPH'S HILLSIDE VILLA	540 E WASHINGTON STREET WEST POINT, NE 68788

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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E 0039 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Conduct testing and exercise requirements.** Based on record review and staff interviews, the facility failed to conduct exercises to test the emergency plan annually. Findings are: A record review of the Elopement/Missing Person Mock Drill, dated 02/01/19, revealed the last time the facility conducted an emergency event drill identified by the risk assessment was at that time. There was no current emergency event drills identified by the risk assessment conducted by the facility. During an interview with the Chief Nursing Officer (CNO) on 08/11/20 at 1:32 PM, (gender) stated that the facility had an Elopement/Missing person mock drill on 02/01/19. The CNO further stated that it was within the last year's survey, dated 01/31/19, and that it would count as part of the emergency preparedness plan. The CNO understood after being told that drills must be done annually. The CNO stated that it was a mistake and would be corrected. During an interview on 08/11/20 at 5:20 PM, the Administrator stated it was a mistake and it would be corrected.
F 0576 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Ensure residents have reasonable access to and privacy in their use of communication methods.** Based on observation and interviews, the facility failed to ensure residents received their mail or other materials on the weekends for four (Residents 2, 3, 22 and 24) of four sampled residents. Findings are: On 08/10/20 at approximately 8:00 AM, Sunday and Monday local newspapers were observed rolled up on the floor next to the inside second door to the facility. There were also five unopened letters sitting in a box container outside the second inner door to the facility. On 08/11/20 the surveyor met with four residents at the Resident Council meeting. At approximately 9:35 AM, Resident 2 stated that (gender) did not receive the Sunday or Monday newspapers along with personal mail until that morning (Tuesday). Resident 2 also stated this was a concern because nobody gave out the newspapers, mail, or packets on the weekends. The other three residents agreed with this statement. On 08/11/20 at approximately 1:10 PM, the Assistant Administrator stated they would collect the newspapers, mail, or packets to give out to the residents but not on the weekends. The Assistant Administrator did not know who would give out newspapers, mail, or packets on the weekends.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment for two (Residents 26 and 27) of 15 residents whose MDSs were reviewed. Findings are: 1. Resident 26 was admitted with [DIAGNOSES REDACTED]. Resident 26's Minimum Data Set (MDS) assessment, dated 06/25/20, revealed (gender) cognition to be severely impaired and (gender) had an active infection of pneumonia. Physician orders, dated for June 2020, did not reveal antibiotic medications for pneumonia infection. Resident 26's Medication Administration Record [REDACTED]. On 08/11/20 at 3:00 PM, an interview was conducted with the Resident Assessment Coordinator (RAC). RAC stated (gender) coded the MDS for an active infection which the resident did not have at the time of the assessment and it was a coding error. On 08/11/20 at 3:16 PM, an interview was conducted with the Chief Nursing Officer (CNO) who stated (gender) expected the MDS to be coded accurately. 2. Resident 27 was admitted to the facility with [DIAGNOSES REDACTED]. Resident 27's Minimum Data Set (MDS) assessment dated [DATE] revealed (gender) cognition was intact, the resident had an active infection of pneumonia, and was on a prescribed weight loss regimen. The resident's height was 64 inches and weight was 92 pounds (LBS). Resident 27's care plan, updated 03/30/20, included a focus of a nutritional problem related to Basal Metabolic Index (BMI) of 16.5, indicating underweight status. Interventions included fortified cereal daily at breakfast and fortified meals with extra gravy and butter to foods. Physician orders [REDACTED]. Resident 27's Medication Administration Record [REDACTED]. Resident 27's weights were documented as follows: 04/09/20: 86 LBS 05/09/20: 85.8 LBS 06/08/20: 91 LBS 07/06/20: 94 LBS 08/10/20: 102 LBS. On 08/11/20 at 11:16 AM, an interview was conducted with Resident 27 who stated (gender) did not have an infection and had gained about 20 LBS since being admitted to the facility and was doing better. On 08/11/20 at 3:00 PM, an interview was conducted with the Resident Assessment Coordinator (RAC) who stated (gender) coded the MDS for an active infection, which the resident did not have at the time of the assessment. The RAC stated the prescribed weight loss regimen was also a coding error, and (gender) would correct them. On 08/11/20 at 3:16 PM, an interview was conducted with the Chief Nursing Officer (CNO) who stated the MDS was expected to be coded accurately.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of policy and procedures, the facility failed to ensure a Preadmission and Annual Resident Review (PASARR) was completed prior to admission for one (Resident 14) of one sampled resident whose clinical record was reviewed for PASARR. Findings are: The facility's Preadmission and Annual Resident Review (PASARR) Policy, undated, documented: . The facility will participate in or complete the Level 1 screen for all potential admissions regardless of payer source to determine if the individual meets the criterion for mental disorder, .intellectual disability.or related condition. Resident 14 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The onset date for all the above [DIAGNOSES REDACTED]. There was no documentation in the clinical record which indicated a PASARR Level 1 had been completed prior to the resident's admission to the facility on [DATE]. On 08/12/20 at 2:15 PM, the Chief Nursing Officer was asked if a PASARR Level 1 had been completed for Resident 14 prior to admission to the facility. The CNO stated no PASARR Level 1 had been completed for the resident upon admission, but should have been completed prior to admission.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and review of policy and procedures, the facility failed to ensure their policy and procedure was followed for the administration of medications via a feeding tube for one (Resident 20) of one sampled resident observed during the administration of medications via feeding tube. Findings are: The facility's Administering Medications through an Enteral Tube, policy and procedure, dated 02/01/20, documented: .Steps in the Procedure.Verify placement of feeding tube.If administering more than one medication, flush with 15 mL (milliliters) warm water (or prescribed amount) between medications. Resident 20 was admitted with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), dated [DATE], documented the resident's Brief Interview for Mental Status score was 14, which indicated the resident was cognitively intact. The MDS documented the resident had a feeding tube. The care plan, most

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

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) recently reviewed/revised 08/03/20, documented the resident had a feeding tube. An intervention included to, Check for tube placement and gastric contents/residual volume per facility protocol and record. On 08/11/20 at 11:04 AM, Licensed Practical Nurse (LPN)-A was observed as she administered three medications via feeding tube to Resident 20. Prior to the administration of the medications, the LPN did not check for placement of the feeding tube. During the administration of the medications, the LPN did not flush the feeding tube with 15 mL of water between the medications. On 08/12/20 at 10:17 AM, LPN-A was asked if (gender) had checked for placement of the feeding tube prior to administering medications to Resident 20. LPN-A stated, No. When asked if (gender) had flushed the feeding tube with 15 mL of water between the medications, LPN-A stated, No. On 08/12/20 at 10:30 AM, the above observation of medication administration via feeding tube and the facility's policy and procedure for medication administration via feeding tube was reviewed with the Chief Nursing Officer (CNO). When asked if LPN-A had followed the facility's policy and procedure to check for placement and to flush with 15 mL of water between medications, the CNO stated, Obviously not.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of policy and procedures, the facility failed to ensure one (Resident 21) of three sampled residents reviewed for unnecessary medications who received antipsychotic medication was monitored for side effects of the medication. Findings are: The facility's Adverse Medication Reactions policy, dated 05/2018, documented the facility, evaluates medication usage in order to prevent and detect adverse consequences and related problems such as adverse reactions and side effects.Residents and patients receiving any medication that has a potential for an adverse consequence are monitored to ensure that any such consequences are promptly identified and reported.An 'adverse consequence' is defined as an unpleasant symptom or event that is due to or associated with a medication.An adverse consequence may include:.Side effect. Resident 21 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status of 07 out of a possible 15, which indicated the resident had moderate cognitive impairment. The MDS documented Resident 21 had received antipsychotic, antianxiety, and antidepressant medications on seven of seven days prior to the assessment date and the antipsychotic medication was administered on a routine basis only. The care plan, most recently reviewed/revised 04/05/20, documented the resident's problems included the use of [MEDICAL CONDITION] medication, including [MEDICATION NAME] (an antipsychotic), [MEDICATION NAME] (antidepressant and nerve pain medication), [MEDICATION NAME] (antianxiety), and [MEDICATION NAME] (antidepressant but more commonly used as a sleep aid). An intervention for the problem included: AIMS (Abnormal Involuntary Movement Scale) assessments per protocol for antipsychotic medications. physician's orders [REDACTED]. There was no documentation in the clinical record which indicated the facility had monitored Resident 21 for side effects of the [MEDICAL CONDITION] medications. On 08/13/20 at 9:21 AM, the Chief Nursing Officer (CNO) was asked if Resident 21 had been monitored for side effects of the [MEDICAL CONDITION] medication. The CNO stated no side effect monitoring had been completed this year. The CNO was shown the care plan intervention for AIMS assessments per protocol for antipsychotic medications. When asked what the facility protocol was, the CNO stated the MDS coordinator was completing an AIMS every six months. (Gender) stated there was no written protocol pertaining to the time frame required to complete an AIMS.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and review of policy and procedures, the facility failed to ensure a medication error rate of less than 5%. The facility's medication error rate was 6.9%, which resulted from two errors in 29 opportunities. This affected one (Resident 3) of six residents who were observed receiving medications during the medication pass. Findings are: The facility's Administering Inhalers policy, dated 02/15/20, documented the following: .Instruct the resident to inhale deeply and hold for several seconds.Repeat inhalation, if ordered. Allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications. The package insert for [MEDICATION NAME] Inhaler documented: After using your [MEDICATION NAME] Inhaler.Rinse your mouth with water and spit it out. Don't swallow the water. Resident 3 was admitted with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A physician's orders [REDACTED]. Rinse mouth after use. On 08/12/20 at 8:01 AM, Licensed Practical Nurse (LPN)-B was observed as she administered the inhalers to Resident 3. The LPN handed the [MEDICATION NAME] inhaler to the resident. The resident took two puffs approximately 2-3 seconds apart. Approximately 10 seconds after (gender) had used the [MEDICATION NAME] inhaler, the resident picked up the Incruse Ellipta inhaler and took a puff of it. Following the administration of the two inhalers, the resident proceeded to take oral medications. (Gender) did not rinse and spit. LPN-B did not instruct Resident 3 to wait at least one minute between puffs of the [MEDICATION NAME], did not instruct (gender) to rinse and spit following the [MEDICATION NAME] administration. The LPN did not instruct the resident to wait at least two minutes between the two inhalers. On 08/12/20 at 9:13 AM, Resident 3 was interviewed. When asked if (gender) waited a minute between puffs of the [MEDICATION NAME] inhaler, (gender) stated (gender) did not. When asked if the nurse had ever asked (gender) to rinse and spit after using the [MEDICATION NAME] Inhaler, (gender) stated no nurse had instructed (gender) to rinse and spit out the water. (Gender) stated (gender) had not been instructed to wait at least one minute between puffs of [MEDICATION NAME] or between the use of the Incruse Ellipta and the [MEDICATION NAME] Inhaler. On 08/12/20 at 9:22 AM, LPN-B stated the resident had not waited at least one minute between puffs of [MEDICATION NAME] and/or between puffs of the [MEDICATION NAME] Inhaler and the Incruse Ellipta inhaler. LPN-B acknowledged (gender) had not instructed the resident to wait one minute between puffs. When asked if (gender) had requested the resident to rinse and spit following the use of the [MEDICATION NAME] Inhaler per the manufacturer's instructions, (gender) stated, No. (Resident 3) takes (gender) pills and swallows after using the inhaler. On 08/12/20 at 10:30 AM, the above observations of the administration of the inhalers was reviewed with the Chief Nursing Officer (CNO). When asked if (gender) agreed the manufacturer's instructions should be followed, (gender) stated, Yes. When asked if the LPN followed the manufacturer's instructions or the facility's policy for the administration of the inhalers, the CNO stated, Obviously (gender) didn't because you just said she didn't.
F 0838 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.** Based on interviews and record review, the facility failed to review and update the Facility Assessment annually. The current facility census was 41 residents. Findings are: A review of the most recent facility assessment, updated on 11/2018 and reviewed on 01/2019, failed to document the current Administrator, Chief Nursing Officer and most of the administrative staff. The average daily census was documented as 15. On 08/12/20 at 11:03 AM, an interview was conducted with the Administrator, who stated the Facility Assessment should have been updated on 01/2020, the same month (gender) started at the facility, but (gender) had other things to look at first. The Administrator stated the current average daily census was 42, but thought the assessment was current as far as reflecting the staff and residents that were in the facility.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, facility policy and Centers for Medicare and Medicaid Services (CMS) guidelines, the facility failed to: 1. Follow transmission based precautions for isolation for a new resident admission with an unknown status of COVID-19 for one of one sampled residents (Resident 192) who had been newly admitted within the past 14 days; and 2. Ensure handheld nebulizer (HHN) equipment was properly cleaned/stored to prevent cross contamination and changed weekly per physician's orders [REDACTED]. Findings are: Referenced to CMS Memorandum QSO-20-28-NH which stated

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) the following: Patients hospitalized for [REDACTED]. However, to ensure they are not infected, nursing homes should place them in Transmission-Based Precautions in a separate observation area or in a single room until 14 days have elapsed since admission. 1. Review of a facility policy titled, COVID-19 Prevention and Control, was revised on 05/29/20. Section Phase 3, #6 included: new admissions/readmissions would be placed in isolation for 14 days; isolation carts would be in place; and Personal Protective Equipment (PPE) available for staff. Resident 192 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 192's admission nursing assessment, dated 08/04/20, revealed Resident 192 needed limited assistance from staff for activities of daily living. Resident 192's initial care plan, dated 08/10/20, included as a focus, a 14-day COVID-19 observation due to being a new admission to the facility. Interventions included needing help to go to activities as (gender) was dependent on staff for meeting emotional, intellectual, physical and social needs related to physical limitation. Resident 192's cognitive assessment, dated 08/10/20, revealed moderately impaired cognition. On 08/10/20 at 8:49 AM, CNA-B stated Resident 192 was the only resident on the 300 hall in isolation as (gender) was a new admission. On 08/10/20 at 8:59 AM, a continuous observation was conducted on the 300 hall outside of Resident 192's room. There was no signage on resident 192's door indicating isolation of any type. There was no PPE outside of the door to Resident 192's room. The Infection Control Preventionist (ICP) went into Resident 192's room wearing a mask, no additional PPE and spoke with Resident 192. The ICP then asked CNA-A to get the weight of Resident 192. At 9:00 AM on 08/10/20, CNA-A went into Resident 192's room with masks and gloves on and shut the door. Shortly after, CNA-B knocked on the door to resident 192's room and entered with a mask on, but no gown or gloves, and exited the room shortly after. CNA-B stated the resident was going to get (gender's) weight taken. CNA-A came out of Resident 192's room pushing Resident 192 in a wheelchair, with the resident wearing a mask. As CNA-A was getting ready to exit the double closed doors to the unit with the resident, (gender) was asked where they were going by the State Surveyor. CNA-A stated they were going out of the unit to get Resident 192's weight. At 9:08 AM on 08/10/20, CNA was informed Resident 192 could only go out of the unit if there were no other residents in the hall, so Resident 192 back to (gender) room. The CNA-A was wearing gloves and mask, but no other PPE. On 8/10/20 at 9:11 AM, an interview was conducted with CNA-A who stated (gender) was trained in orientation about handwashing and using hand sanitizer between residents and when passing trays. CNA-A stated new admission residents were required to stay in their rooms for 14 days and staff were required to wear masks and wash hands when conducting care. CNA-A stated there was no sign on the door for the isolation notification because staff was informed in morning report which residents were on isolation. On 08/10/20 at 10:34 AM, an interview was conducted with Housekeeper-A cleaning Resident 192's room and going back and forth from the room to the cart for supplies. Housekeeper-A stated the manager notified (gender) of which residents were on quarantine, and so (gender) knew Resident 192 was on isolation. The housekeeper stated (gender) did not do anything different cleaning rooms for isolation residents, except for cleaning their room last. The housekeeper stated there were no residents with COVID-19, only residents on quarantine. On 08/10/20 at 10:38 AM, an interview was conducted with the Licensed Practical Nurse (LPN)-C, who stated staff washed hands and used a mask when going in and out of the isolation room. (Gender) stated staff would use gloves if working with the resident. LPN-C stated Resident 192 did not come out of the room for therapy or meals. LPN-C stated staff knew the resident was on isolation because that information was conveyed in report. On 08/10/20 at 10:41 AM an interview was conducted with the ICP who stated Resident 192 could come out of the room, and off the hall to get weighed as long as (gender) was the last one to get weighed. On 08/10/20 at 11:05 AM a therapist was observed to be working with Resident 192 in the room. The therapist wore gloves and a mask, but no other PPE. On 08/10/20 at 2:06 PM, an interview was conducted with the Chief Nursing Officer (CNO). (Gender) stated the facility did not test residents at this point. The CNO stated the hospitals were not testing residents either and the only protocol was isolation for 14 days. The CNO stated the facility was treating newly admitted residents as if they had been exposed, but not as if they were positive, and they were doing what they had been advised by the state Infection Control Assessment and Promotion Program (ICAPS) as far as what PPE was needed. The CNO stated no signage for a resident's door was needed, to instruct what PPE to wear, because staff were notified in report and visitors were not allowed to visit on resident halls. The CNO stated since the facility was in Phase 3 level of restrictions, (gender) was under the impression that all the PPE they needed for a new admission with unknown COVID-19 status, was to use gloves and masks. The CNO then stated wearing PPE after the facility went to Phase 3 was hit or miss and staff would be educated on what was required. On 08/12/20 at 2:03 PM, an interview was conducted with the Administrator, who stated (gender) remembered from a webinar from ICAPS, if no COVID-19 residents or staff were in the building, they only had to monitor residents including new admissions. 2. The facility's, Administering Medications through a Small Volume (handheld) Nebulizer, policy and procedure, dated 02/01/20, documented: When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup.Rinse and disinfect the nebulizer equipment according to facility protocol, or: a. Wash pieces with warm, soapy water; b. Rinse with hot water; c. Allow to air dry.When equipment is completely dry, store in a plastic bag with the resident's name and date on it. Change equipment and tubing every seven days, or according to facility protocol. Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status of 15, which indicated (gender) was cognitively intact, and was independent or required supervision with most activities of daily living. The care plan, most recently reviewed/revised 08/04/20, documented the resident's problems included potential for nutritional risk related to [MEDICAL CONDITION], etc. Appropriate goals and interventions were addressed. A physician's orders [REDACTED]. A physician's orders [REDACTED]. On 08/10/20 at 10:37 AM, Resident 3 stated (gender) received an HHN treatment twice daily. The HHN tubing was not dated, the mouthpiece was sitting inside a Kleenex box, and moisture droplets were in the medication cup. On 08/11/20 at 12:41 PM, the HHN tubing was not dated, the mouthpiece was laying on the overbed table surface, and moisture droplets were in the medication cup. On 08/11/20 at 12:43 PM, Licensed Practical Nurse (LPN) C was asked how often the HHN tubing and mouthpiece was supposed to be changed and/or cleaned. She stated the tubing and mouthpiece were supposed to be changed on Saturdays. She stated the HHN equipment was supposed to be rinsed and placed on a paper towel in the bathroom to dry after each use. On 08/12/20 at 12:01 PM, the HHN tubing was not dated, the mouthpiece was laying on a box of Kleenex on the resident's overbed table, and moisture droplets were in the medication cup. The Treatment Administration Records (TARs) for 06/2020, 07/2020, and 08/2020 were reviewed. There was no documentation the resident's HHN tubing had been changed since at least 06/01/20. On 08/12/20 at 12:05 PM, the Chief Nursing Officer (CNO) was interviewed. When asked for a policy for changing nebulizer tubing, (gender) stated there was no policy. (Gender) stated tubing was supposed to be dated and was supposed to be changed weekly on Sundays. On 08/12/20 at 1:45 PM, LPN B was interviewed. When asked if (gender) had administered an HHN treatment to Resident 3, (gender) stated (gender) had administered a treatment before 7:00 AM. When asked if she knew what the facility's policy and procedure was for cleaning the HHN equipment, (gender) stated, I do not. The night shift usually cleans it. The facility's policy and procedure was reviewed with LPN B and when asked if (gender) had followed the policy cleaning and storing the HHN equipment, (gender) stated (gender) had not disconnected the T-piece, mouthpiece and medication cup since the treatment was given before breakfast. On 08/12/20 at 2:22 PM, the CNO was asked the last time there was documentation the HHN equipment had been changed. (Gender) stated (gender) could not find documentation of when the HHN tubing had been changed last.