| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265715 | A. BUILDING _____ B. WING _____ | 04/30/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| SUNNYVIEW NURSING HOME & APARTMENTS | 1311 E 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) |
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| F 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews and record reviews, the facility failed to inform one sampled resident's (Resident #1) responsible party after the resident had a significant weight loss and after a fall. The facility census was 74. Review of the facility's undated Change in Resident's Condition or Status policy showed: - Unless otherwise instructed by the resident, the nurse supervisor or designee will notify the resident's next of kin or representative (sponsor) when: -The resident is involved in any accident or incident that results in an injury including injuries of an unknown source, or an injury or accident that has the potential for requiring physician intervention. -There is a significant change in the resident's physical, mental or psychosocial status; -There is a need to alter the resident's room assignment; -A decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital 1. Review of Resident #1's facesheet showed - The Resident was admitted on [DATE] with unspecified pain, major [MEDICAL CONDITION], cardiac arrhythmia (improper beating of the heart), hypertension and [MEDICATION NAME] degeneration (an eye disease that causes vision loss). Review of Resident #1's medical record showed: - A letter of incapacitation (a letter signed by two physicians who have determined the resident has lost his/her decisional capacity and invoking the power of attorney) dated 6/4/2019. Review of a dietary note, dated 1/13/20 at 3:26 P.M. and signed by the Dietary Manager showed: -Resident's current weight is 128 pounds (lbs). This is down 13 lbs since last month. He/she is on a regular diet and is receiving 4 ounces (oz. ) of Power Shakes with all of his/her meals and snacks twice daily. Both for added calories related to history of poor meal intake and weight loss. Resident will have weight monitored weekly. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 3/18/20 showed: -Severe Cognitive impairment; -[DIAGNOSES REDACTED]. -Unsteady gait; Supervision with transfers and independent with ambulation; -Uses a walker or wheelchair -Limited assistance with toileting; occasionally incontinent of urine, always incontinent of bowel; -No history of falls Review of nurses' note, dated 3/30/20 at 2:37 P.M., and signed by Licensed Practical Nurse (LPN) B, showed: -The nurse sent fax to the physician regarding resident's weight loss of 5 lbs. this week. Requesting Ensure or supplement of some sort for weight loss. Review of nurses' note, dated 3/30/20 at 4:33 P.M. and signed by LPN B, showed: -Physician returned fax regarding resident weight loss and requested that staff continue to monitor and update the physician next week with weight. Review of nurses' note, dated 4/20/20 at 1:57 P.M. and signed by LPN B, showed: -Physician returned fax regarding resident weight loss from 3/1/20 to 4/14/20. Resident has gone from 131 lbs. to 118 lbs. Physician has okayed for Power Shakes and Magic Cups of ice cream twice daily for added calories. Review of nurses' note, dated 4/20/20 at 2:06 P.M. and signed by LPN B, showed: -The nurse sent a memo to dietary regarding the added shakes and ice cream twice daily. Review of nurses' note, dated 4/21/20 at 4:59 P.M. and signed by LPN A, showed: -Resident fell at 12:15 today and when the nurse got to the resident's room, he/she was sitting on his/her bottom in front of his/her closet. Resident states I got up out of my wheelchair and tried to put my coat on by myself. Resident denied hitting his/her head and stated that only his/her bottom hurt. Resident was picked up off floor and placed back in his/her wheelchair. The nurse helped him/her put his/her jacket on and told him/her that he/she needed to ask for help more often if he/she needs it. Resident laughed and stated I definitely won't be doing that again by myself. Faxed Physician to notify and shift vitals initiated. Review of nurses' notes, dated 4/22/20 at 6:28 A.M., and signed by LPN A, showed: -Physician faxed back regarding resident fall and stated noted and monitor. Review of nurses' noted, dated 4/22/20 at 9:13 A.M., and signed by LPN A, showed: -Resident complaining of left hip pain when he/she tried to move it too much or put pressure on it. Resident stated that he/she can hardly bear weight on it while trying to walk around his/her room. Faxing Physician. Review of nurses' noted, dated 4/22/20 at 11:28 A.M., and signed by LPN A, showed: -Resident continued on post fall vital signs. Resident complaining of pain in the left hip area and cannot hardly bear weight. The nurse helped aide take the resident to the shower room and resident was showered. Review of nurses' noted, dated 4/23/20 at 12:06 P.M., and signed by LPN A, showed: -Physician responded back to fax due to resident fall and having hip pain. He/she stated x-ray left hip and send me results as soon as possible (ASAP). Mobile x-ray order was faxed to the mobile x-ray provider. Resident's Durable Power of Attorney (DPOA) was called and informed of this but no answer, so the nurse left a voicemail. Review of the resident's medical record showed faxed notification to the physician of his/her significant weight loss and notifying of his/her fall on: 3/30/20, 4/16/20, 4/21/20, 4/22/20 and 4/23/20. Review of the resident's medical records from 1/13/20 through 4/22/20 showed no notification of the Resident's representative of his/her weight loss or his/her fall. During an interview on 4/24/20 at 12:48 P.M., the DPOA said: -He/she last saw the resident in early February and has not been able to visit the resident recently due to the recent COVID-19 restrictions; -He/she was not notified of the resident's fall or the resident's significant weight loss until 4/23/20; -The resident's weight is now 115 lbs. and the resident's current weight is is really small for him/her; -The resident complained of pain to the left hip and left leg when he/she spoke to the resident on the telephone; -The resident is unable to bear weight to his/her left lower leg and is needing to use a wheelchair for all mobility; -He/she was told that an x-ray was ordered by the physician and would be performed on 4/23/20; -No x-ray has been performed yet because the mobile x-ray company had not received the fax from the facility; -He/she feels that he/she should have been notified immediately after the resident's fall and prior to 4/23/20 regarding the resident's significant weight loss. During an interview on 4/27/20 at 11:24 A.M., the Director of Nurses (DON) said: -The resident has been declining over the last six months -The resident can be difficult to redirect at times During an interview on 4/28/20 at 12:24 P.M., the Care Plan/MDS Coordinator said: -Residents are weighed by the Restorative Aide as ordered by the physician and reported to the MDS Coordinator -He/she completes the weight variance reports for the facility and is aware of resident weight gains/losses; -He/she did not notify the resident's representative of the resident's weight loss; -Nursing staff should notify the resident's representative of any changes in the resident's condition and any changes to the resident's treatment plan; During an interview on 4/28/20 at 1:19 P.M., the Dietary Manager said: -The resident's weight loss was discussed in the risk meeting last week; -He/she recommended that the resident's nutritional supplements be changed to Mighty Shakes and Magic Cups twice daily as the current nutritional supplements were not successful in preventing resident weight loss. -He/she did not notify the resident's representative of the treatment changes or the weight loss; -Nursing staff should notify the resident's representative of any changes in the resident's condition and any changes to the resident's treatment plan; During an interview on 4/28/20 at 1:37 P.M., LPN A said: -He/she was working the day of the resident's fall; -He/she faxed the physician notifying the physician of the resident's fall; -He/she believes that the resident's family should be notified of a resident fall within 24 hours. -He/she did not notify the resident's representative of the resident's fall because there were two resident falls on his/her shift and he/she got busy and forgot; During an interview on 4/28/20 at 3:27 P.M., LPN B said: -He/she is aware of the resident's significant weight |

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 0580<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>loss; -He/she found a faxed order from the resident's physician for nutritional supplements for weight loss; -He/she updated the resident's dietary orders and notified the dietary department; -He/she states I should have called his/her family with the new orders but I didn't call them; -He/she states that it is an expectation of nursing staff to notify the resident's family of changes in the resident's condition or changes in the treatment plan During an interview on 4/30/20 the Administrator said: -He would expect the resident's responsible party and/or DPOA to be notified of any changes in the resident's condition. MO 9 |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interviews, the facility failed to implement a care plan and interventions for falls after the resident had a fall. The facility also failed to implement a care plan for weight loss after the resident had an 18.44% weight loss in four months for one sampled resident (Resident #1) and failed to implement a care plan and intervention for a two additional residents (Resident #2 and #4) who had a significant weight loss. Resident #2 had a weight loss of 8.07% in two months and Resident #4 had a 13.86% weight loss in 3 months. The facility census was 74. The facility did not provide a policy for the development of care plans. Review of the facility's Nutrition (Impaired)/Unplanned Weight Loss policy, dated 12/2011, showed: - Monitoring: The Physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include: -Evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals. -The Physician, with input from the staff, will determine the most appropriate intervals for weight assessments. Review of the facility policy for falls and fall risks dated 12/07 showed: -Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; -The staff, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions the staff may choose to prioritize interventions; -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant; -If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable; -In conjunction with the attending physician, staff will identity and implement relevant interventions to try to minimize serious consequences of falling; -The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling; -If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has resolved; -If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified; -The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist and continue to present a risk for falling or injury due to falls. 1. Review of Resident #1's facesheet showed the resident was admitted on [DATE] with unspecified pain, major [MEDICAL CONDITION], cardiac arrhythmia (improper beating of the heart), hypertension and [MEDICATION NAME] degeneration (an eye disease that causes vision loss). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 3/18/20 showed: -Severe cognitive impairment; -[DIAGNOSES REDACTED]. -Unsteady gait; Supervision with transfers and independent with ambulation; -Uses a walker or wheelchair -Limited assistance with toileting; occasionally incontinent of urine, always incontinent of bowel; -No history of falls Review of Resident #1's basic weight history showed the following weights: -12/1/19 weight of 141 lbs. -12/27/19 weight of 134 lbs. -1/1/20 weight of 134 lbs. Review of the dietary note, dated 1/13/20 at 3:26 P.M. and signed by the Dietary Manager (DM) showed: -Resident current weight is 128 lbs. This is down 13 lbs. since last month. He/she is on a regular diet and is receiving 4 oz. Power Shakes with all of his/her meals and snacks twice daily. Both for added calories related to history of poor meal intake and weight loss. Resident will have weight monitored weekly. Review of Resident #1's basic weight history showed the following weights: -2/2/20 weight of 132 lbs. -2/9/20 weight of 129 lbs. -2/15/20 weight of 132 lbs. -2/23/20 weight of 132 lbs. -3/1/20 weight of 131 lbs. -3/10/20 weight of 127 lbs. Review of facility documentation, the Resident Weight Variance Worksheet, dated 3/12/20 and signed by the MDS Coordinator showed: -Weight loss of 4 lbs for the week. Continue to monitor. Increased confusion Review of Resident #1's basic weight history showed the following weights: -3/15/20 weight of 126 lbs. Review of facility documentation, the Resident Weight Variance Worksheet, dated 3/19/20 and signed by the MDS Coordinator showed: -Weight loss of 1 lb. for the week. Continue to monitor. Ice cream as a snack. He/she is frequently asleep at dinner. Review of facility documentation, the Resident Weight Variance Worksheet, dated 3/26/20 and signed by the MDS Coordinator showed: -Weight loss of 1 lb. Confused. Review of facility documentation, the Resident Weight Variance Worksheet, dated 4/2/20 and signed by the MDS Coordinator showed: -Weight loss of 5 lbs. Power Shake. Encourage snacks. Review of Resident #1's basic weight history showed the following weights: -4/4/20 weight of 120 lbs. -4/14/20 weight of 118 lbs. Review of facility documentation, the Resident Weight Variance Worksheet, dated 4/16/20 and signed by the MDS Coordinator showed: -Mighty shake and Magic cup added. Weight loss of 4 lbs. for the week. Review of Resident #1's basic weight history showed the following weights: -4/19/20 weight of 115 lbs. -4/21/20 weight of 115 lbs. Review of facility documentation, the Resident Weight Variance Worksheet, dated 4/23/20 and signed by the MDS Coordinator showed: -Weight 115 lbs. Down 3 lbs. Occupational Therapy (O.T.) is picking him/her up to address this. Review of the resident's medical records showed a significant weight loss with no updates to the care plan after 1/13/20 to prevent further weight loss. During an interview on 4/28/20 at 12:24 P.M., the Care Plan/MDS Coordinator said: -Residents are weighed by the Restorative Aide as ordered by the physician and reported to the MDS Coordinator; -He/she completes the weight variance reports for the facility and is aware of resident weight gains/losses; -He/she had not updated the resident's care plan to include current strategies to prevent weight loss prior to 4/27/20. 2. Review of Resident #1's nurses' note, dated 12/29/19 at 11:15 A.M. and signed by Registered Nurse (RN) B showed: -Heard resident yelling, upon entering room resident was found sitting on the floor in front of his/her recliner. He/she stated he/she was reaching for his/her pads under his/her side table and slid out of his/her wheelchair. Denies hitting head or any pain at this time. No redness or bruised areas noted,moved all extremities within his/her normal limits. Assisted to standing position by two staff members and then to his/her wheelchair. Aide assisted resident to bathroom to change his/her pad then to recliner. Call light within reach. Will continue to monitor. Review of the resident's medical records showed a fall in December 2019 with no care plan or interventions to prevent further falls Review of nurse's note, dated 4/21/20 at 4:59 P.M. and signed by Licensed Practical Nurse (LPN) A, showed: -Resident fell at 12:15 today and when the nurse got to the resident's room, he/she was sitting on his/her bottom in from of his/her closet. Resident stated I got up out of my wheelchair and tried to put my coat on by myself. Resident denied hitting his/her head and stated that only his/her bottom hurt. Resident was picked up off floor and placed back in his/her wheelchair. The nurse helped him/her put his/her jacket on and told him/her that he/she needed to ask for help more often if he/she needs it. Resident laughed and stated I definitely won't be doing that again by myself. Faxed Physician to notify and shift vitals initiated. Review of the medical record showed a fall on 4/21/20 with no care plan or interventions to prevent further falls. During an interview on 4/28/20 at 12:24 P.M., the Care Plan/MDS Coordinator said: -He/she began in the position in October 2019; -He/she reviews and updates resident care plans quarterly and annually, with any changes to the resident's condition, with any resident falls or any changes to the resident's treatment plan; -Changes in any resident's condition or changes to resident treatment plans are communicated to him/her and to other departments in the weekly Risk meeting and in the communication meetings each morning; -Care plan strategies and goals are a collaborative effort across all disciplines and should be evaluated and updated if not improving the resident's outcomes. -He/she did not initiate any fall prevention strategies on the care plan because he/she was unaware of any previous falls; 3. Review of Resident #2's quarterly MDS dated [DATE] showed: -Severe cognitive impairment; -[DIAGNOSES REDACTED].; without a weight loss/gain of 5% or more in the last month or 10% or more loss/gain in the last six months; -Limited assistance with 1 staff member for all ADL's, except personal hygiene and bathing requiring extensive assistance -Unsteady gait, uses walker Review of the basic weight history showed the following weights: -2/2/20 weight of 161 lbs. -3/1/20 weight of 159 lbs. -4/4/20 |

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| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2)<br>weight of 151 lbs. -4/18/20 weight of 149 lbs. Review of the basic weight history showed a 8.07% weight loss in 3 months. Review of the resident's medical records showed a significant weight loss with no updates to the care plan after 11/13/19 to prevent further weight loss. 4. Review of Resident 4's quarterly MDS, dated [DATE] showed: -Severe cognitive impairment; -[DIAGNOSES REDACTED].-Minimal assistance/Supervision needed with eating; no swallowing issues; -Weight of 127 lbs; with a weight loss of 5% or more in the last month or 10% or more loss in the last six months and no physician prescribed regimen for weight loss. -Non-ambulatory with extensive assistance by two staff members for transfers to/from wheelchair; -Extensive assistance with two staff members for all other ADL's including transfers, dressing and bathing; -Uses a walker or wheelchair Review of Resident #4's basic weight history showed the following weights: -2/2/20 weight of 137 lbs. -2/9/20 weight of 140 lbs. -2/15/20 weight of 135 lbs. -2/23/20 weight of 135 lbs. -3/1/20 weight of 135 lbs. -3/10/20 weight of 134 lbs. -3/15/20 weight of 131 lbs. -4/2/220 weight of 127 lbs. -4/14/20 weight of 123 lbs. -4/19/20 weight of 121 lbs. -4/26/20 weight of 118 lbs. Review of Resident #4's basic weight history showed a 13.86% weight loss in 3 months. Review of the resident's medical records showed a significant weight loss with no updates to the care plan after 2/28/20 to prevent further weight loss. During an interview on 4/30/20 at 2:30 P.M. the Administrator said: -He expects the resident's care plan be updated as needed. MO 9 |
| F 0658<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure services provided by the nursing facility meet professional standards of quality.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interviews, the facility failed to provide care and treatment in accordance with professional standards of practice and staff failed to follow their policy and follow physicians orders to obtain an x-ray for one resident (Resident #1) after a fall and failed to notify the physician when one additional resident (Resident #2) had a significant weight loss. The facility census was 74. Review of the undated facility policy for Change in a Resident's Condition or Status showed: -Our facility shall promptly notify the resident and/or representative and the attending physician of changes in the resident's condition and/or status; -The nurse or designee will notify the resident's attending physician when: the resident is involved in any accident or incident that results in an injury including injuries of an unknown source, or an injury or accident that has the potential for requiring physician intervention; there is a significant change in the resident's physical, mental or psychosocial status; there is a need to alter the resident's treatment significantly; the resident repeatedly refuses treatment or medications; 1. Review of Resident #1's face sheet showed the resident was admitted on [DATE] with unspecified pain, major [MEDICAL CONDITION], cardiac arrhythmia (improper beating of the heart), hypertension and [MEDICATION NAME] degeneration (an eye disease that causes vision loss). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 3/18/20 showed: -Severe cognitive impairment; -[DIAGNOSES REDACTED].' note, dated 12/29/19 at 11:15 A.M. and signed by Registered Nurse (RN) B showed: -Heard resident yelling, upon entering room resident was found sitting in the floor in front of his/her recliner. He/she stated he/she was reaching for his/her pads under his/her side table and slid out of his/her wheelchair. Denies hitting head or any pain at this time. No redness or bruised areas noted, moves extremities within his/her normal limits. Assisted by two staff members to a standing position and then to his/her wheelchair. Aide assisted resident to bathroom to changed his/her pad then to recliner. Call light within reach. Will continue to monitor. Review of a nurses' note, dated 4/21/20 at 4:59 P.M. and signed by Licensed Practical Nurse (LPN) A, showed: -Resident fell at 12:15 today and when the nurse got to the resident's room, he/she was sitting on his/her bottom in front of his/her closet. Resident states I got up out of my wheelchair and tried to put my coat on by myself. Resident denied hitting his/her head and stated that only his/her bottom hurt. Resident was picked up off floor and place back in his/her wheelchair. The nurse helped him/her put his/her jacket on and told him/her that he/she needed to ask for help more often if he/she needs it. Resident laughed and stated I definitely won't be doing that again by myself. Faxed Physician to notify and shift vitals initiated. Review of the medical record showed a fax communication to the physician dated 4/22/20 showed: -Resident complained of left hip pain this morning while trying to wheel around with his/her wheelchair. Also the resident complained of pain while trying to walk in his/her room. The resident stated I can barely stand on it and put weight on it. May we get an order for [REDACTED]. Review of the nurses' notes dated 4/24/20 at 12:40 P.M. signed by Registered Nurse (RN) A showed: -Responsible party called this nurse and stated that he/she had been notified yesterday of a fall that occurred on 4/23/20, writer told the responsible party -that he/she was not aware of a fall on 4/23/20, but was aware of the fall on 4/21/20 and was needing an x-ray of the left hip. But the x-ray had not been done. During an interview on 4/24/20 at 4:30 P.M. RN A said: -He/she came on duty this morning and found the request for the x-ray with a note attached to be re-faxed as it did not go through; -He/she called the mobile x-ray provider with the order by the physician; -He/she did not notify the physician that the x-ray had not been done on 4/22/20 or 4/23/20 as ordered; -He/she should have notified the physician that the order had not been done. 2. Review of Resident #2's admission MDS dated [DATE] showed: -Alert and oriented with difficulty making decisions; -Independent with eating; -Weight of 154 pounds (lbs). Review of the basic weight history from 2/2/20 to 4/18/20 showed a weight of 161 lbs. documented on 2/2/20 and a weight of 149 lbs. documented on 4/18/20. For a 13 lb. weight loss or an 8.07% weight loss in two months. Review of the medical record showed no documentation of the physician notification of the weight loss. During a telephone interview on 4/30/20 at 2:30 P.M. the Administrator said: -He is not familiar with the policy or protocol for falls or weight loss, the Director of Nursing monitors and reviews the falls and weight loss, and she is not available; -He would expect the nurses to notify the physician as soon as they realize the resident has had a change of condition or if an order by the physician has not been done. MO 9 |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure one resident's (Resident #1) safety, who has a history of falls, when staff failed to obtain a physician order x-ray as ordered by the physician when the resident complained of pain. Staff failed to notify the responsible party of the fall and failed to implement measures to prevent further falls. The facility census was 74. Review of the facility policy for falls and fall risks dated 12/07 showed: -Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling; -The staff, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions the staff may choose to prioritize interventions; -If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant; -If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable; -In conjunction with the attending physician, staff will identity and implement relevant interventions to try to minimize serious consequences of falling; -Staff will notify the resident's family and physician after each incident during a reasonable timeframe within 24 to 72 hours; -The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling; -If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention has resolved; -If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified; -The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist and continue to present a risk for falling or injury due to falls. 1. Review of Resident #1's face sheet showed: -admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the nurses' notes dated 12/28/19 at 11:15 A.M. showed: -Heard the resident yelling, and upon entering the room, the resident was found sitting in the floor in front of his/her recliner. The resident stated he/she was reaching for his/her incontinent pads and slid out of the wheelchair. Review of the medical record dated 12/28/19 through 3/18/20 showed no care plan for falls or for the risk for falls. Review of the quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 3/18/20 showed: -Alert and oriented with difficulty making decisions; -Independent with transfer, walking, eating and personal hygiene. Limited assistance of one staff member for toilet use; -Unsteady when walking and transfer; -No history of falls; -[DIAGNOSES REDACTED]. Review of the Fall Risk assessment dated [DATE] showed: -A total score of 10 or greater, the resident should be considered at high |

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|---|---|---|---|
| | 265715 | A. BUILDING _____ B. WING _____ | 04/30/2020 |

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| SUNNYVIEW NURSING HOME & APARTMENTS | 1311 E 28TH STREET TRENTON, MO 64683 |

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 3)<br>risk for potential falls. A prevention protocol should be initiated immediately and documented on the care plan; -The resident scored a 21. Review of the medical record from 3/20/20 to 4/21/20 showed no care plan for falls or for being at risk for falls. Review of the nurses' notes dated 4/21/20 at 4:59 P.M. signed by Licensed Practical Nurse (LPN) B showed: -The resident fell at 12:15 P.M. When the writer got to the resident room, he/she was sitting on his/her bottom in the room in front of his/her closet. The resident stated: I got up out of my wheelchair and tried to put my coat on by myself. The resident denied hitting his/her head and stated that only his/her bottom hurt. The resident was picked up off the floor and placed back in the wheelchair. This writer helped him/her put his/her jacket on and told him/her that he/she needed to ask for help more often. Faxed the physician. Review of the Falls Investigation assessment dated [DATE] at 5:00 P.M. showed: -The resident had socks and shoes on, was reaching up and was alone. The resident has [DIAGNOSES REDACTED]. Assistive device was ordered. Review of the fax communication to the physician dated 4/21/20 showed: -The resident fell at 12:15 today in his/her room with the physician signature and a note, signed by the physician to please monitor. Review of the nurses' notes dated 4/22/20 at 11:28 A.M. signed by LPN B showed: -Resident continues on post fall vital signs. The resident complained pain in the left hip area and cannot hardly bear weight. Review of the fax communication to the physician dated 4/22/20 showed: -Resident complained of left hip pain this morning while trying to wheel around with the wheelchair. Also complained of pain while trying to walk in the room. May we get an order for [REDACTED].M. signed by LPN B showed: -Physician responded back to fax related to resident's fall and having hip pain. The physician stated: x-ray left hip and send the results as soon as possible. Mobile x-ray order was faxed to mobile x-ray provider. The resident's responsible party was called and informed of this but no answer so this writer left a voicemail. Review of the request for x-ray for mobile x-ray provider dated 4/23/20 showed an order for [REDACTED].M. signed by Registered Nurse (RN) A showed: -The responsible party stated that he/she was not notified of the fall on 4/21/20 until 4/23/20. Writer informed the responsible party of the order for the x-ray. The responsible party requested the x-ray be done immediately and the writer informed the responsible party that he/she wasn't sure how that would be done with the coronavirus, but the request for the x-ray was sent to the facility mobile x-ray provider. During an interview on 4/24/20 at 12:48 P.M., the resident's representative said: -He/she last saw the resident in early February and has not been able to visit the resident recently due to the recent COVID-19 restrictions; -He/she was not notified of the resident's fall until 4/23/20; -The resident complained of pain to the left hip and left leg when he/she spoke to the resident on the telephone; -The resident is unable to bear weight to his/her left lower leg and is needing to use a wheelchair for all mobility; -He/she was told that an x-ray was ordered by the physician and would be performed on 4/23/20; -No x-ray has been performed yet because the mobile x-ray company had not received the fax from the facility; -He/she feels that the facility should have notified him/her immediately after the resident's fall; During an observation and interview on 4/24/20 at 4:15 P.M. the resident did and said: -Resident #1 attempted to stand up from the bed with RN A at his/her side. RN A encouraged the resident to wait for help. The resident stood up, using his/her wheelchair to pull him/herself to a standing position. As the resident began to stand up, he/she moaned out in pain and grabbed his/her left hip and said, It hurts!. RN A did not attempt to assist the resident. -The resident said that he/she fell a couple of days ago and landed on his/her left hip. The left hip has hurt ever since the fall and he/she has had difficulty in walking. During an interview on 4/24/20 at 4:15 P.M. RN A said: -He/she does not usually work with the resident. The resident is usually independent with transfers and wheelchair use. He/she was not notified of the resident's fall when he/she came on duty this morning. He/she was unaware of the order for the x-ray until the social services director asked him/her about the results of the x-ray. He/she looked for the x-ray order and found a note attached to the order that read re-fax to mobile x-ray as the line was busy. He/she called the mobile x-ray provider and requested them to come to the facility. The mobile x-ray provider just left the facility after attempting to get the x-ray of the residents left hip. The resident was not cooperative and the x-ray may not be good. -If an order for [REDACTED]. Review of the nurses' notes dated 4/24/20 at 6:06 P.M. signed by RN A showed: -X-ray tech arrived between 3:30 and 4:00 P.M. Only able to get one view due to the resident being in pain and getting combative. Review of the nurses' notes dated 4/24/20 at 8:43 P.M. showed: -X-ray received with no gross evidence of bony abnormalities noted. Review of the nurses' notes dated 4/25/20 at 12:43 P.M. showed; -The resident has complained of pain in his/his her left leg off and on through out the day. Review of the medical record from 4/21/20 through 4/25/20 showed no care plan for falls, no assessment for the resident to be at risk for falls, or addressing the fall on 4/21/20. During an interview on 4/28/20 at 12:24 P.M., the Care Plan/MDS Coordinator said: -He/she began in the position in October 2019; -He/she reviews and updates resident care plans quarterly and annually, with any changes to the resident's condition, with any resident falls or any changes to the resident's treatment plan; -Changes in any resident's condition or changes to resident treatment plans are communicated to him/her and to other departments in the weekly Risk meeting and in the communication meetings each morning; -Care plan strategies and goals are a collaborative effort across all disciplines and should be evaluated and updated if not improving the resident's outcomes. -He/she did not initiate any fall prevention strategies on the resident's care plan because he/she was unaware of any previous falls; Review of the nurses' note dated 4/28/20 at 1:15 P.M. signed by LPN B showed: -The resident stated that his/her left leg hurt and was given Tylenol. Review of the nurses' note dated 4/28/20 at 2:49 P.M. signed by LPN B showed: - Physician faxed back regarding the resident update and this writer informed the physician that the resident was still having pain in the left hip. The physician ordered an x-ray with two views at the local hospital. This writer called the local hospital to inquire about the x-rays and was told that unless it was emergent, they were not accepting walk-ins due to the coronavirus pandemic. The physician notified and ordered a stat x-ray due to fall and possible fracture. The resident was sent to the hospital for x-rays. During an interview on 4/28/20 at 7:00 P.M. LPN B said: -The resident's x-rays were negative for any fractures. During an interview on 4/29/20 at 1:58 P.M., Certified Medication Technician (CMT) A said: -He/she did not observe the resident's fall but he/she was passing meds on Station 3 the day of the resident's fall. -The resident usually required only stand by assistance for activities of daily living (ADL's) such as transferring to and from his/her wheelchair and while ambulating; -He/she has observed a change in the resident's ability to perform ADL's since the fall and it was a lot harder for him/her to bear weight due to the pain in his/her left hip; -The resident now requires the assistance of two staff members to stand, transfer and for toileting; During an interview on 4/29/20 at 2:21 P.M., Certified Nurse's Aide (CNA) A said: -He/she works with the resident often as he/she weighs the resident each week; -The resident is usually very independent and prefers to do most ADL's on his/her own; -He/she is aware that the resident had a fall in the previous week; -He/she has observed a change in the resident's ability to stand and ambulate since the fall; -The resident is reporting pain to his/her leg and arm, the resident reported to the CNA that his/her leg and arm were broke; During an interview on 4/30/20 at 10:42 A.M., the Registered Occupational Therapist (OTR) said: -He/she was unaware of the residents fall; -During the resident's evaluation, he/she observed the resident having difficulties performing other ADL's related to the resident's pain; -He/she will formulate additional goals and interventions to the residents' plan of care to assist with the resident's recent decline in his/her ability to perform ADL's; During a telephone interview on 4/30/20 at 2:30 P.M. the Administrator said: -He was unable to answer nursing questions and referred this surveyor to the DON. This surveyor informed the Administrator that several attempts were made to contact the DON with no success; -The administrator was asked for what his expectation would be for staff regarding falls, physician notification, responsible party notification and follow up with physicians orders, the administrator stated that he would expect the facility staff to follow the facility policies. MO 9. |
| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record review and interviews, the facility failed to ensure that two sampled residents (Resident #1 and #2) maintained acceptable parameters of nutritional status and failed to implement interventions after the residents experienced a significant weight loss. The facility census was 74. Review of the facility policy for Nutrition (Impaired)/Unplanned Weight loss dated 12/11 showed: -The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparison over time; -As part of the initial assessment, the staff and physician will define the individual's current nutritional status (weight, food/fluid intake, and pertinent laboratory values) and identify individuals with anorexia, recent weight loss, and significant risk for impaired nutrition; -The threshold for significant unplanned and undesired weight loss will be based on the following criteria: one month: 5% weight loss is significant: greater than 5% is severe; three months: 7.5% weight loss is significant; greater than 7.5% is severe; six months: 10% weight loss is significant; greater than 10% is severe; -The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of weight loss and/or impaired nutrition; -The physician will review possible causes of anorexia or weight loss with the nursing staff |

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| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 4)<br>and/or dietitian before ordering interventions; -The dietitian will estimate calorie, nutrient and fluid needs and, with the physician will identify whether the resident's current intake is adequate to meet his or her nutritional needs; -The physician, with the help of the multidisciplinary team, will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss; -The physician will consider whether any additional diagnostic testing is indicated to help clarify the causes of impaired nutrition; -The physician will review carefully, and rule out medical causes of oral or swallowing problems before authorizing other consults or interventions to modify diet consistency; -The physician or staff will document relevant medical observations and conclusions regarding the nature, severity, causes, and consequences of impaired nutritional status, especially in complex situations or where multiple active causes may coexist; -The physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include: evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals. -Monitoring is also required for residents who's current nutritional status is stable. Such monitoring may include: recognizing deviations from the resident's usual habits and preferences, including mealtime habits, snacking and food preferences. Observing for and documenting any decline in appetite and/or food intake. Observing for and reporting significant weight gain or loss. Recognizing symptoms such as nausea, anorexia, and diarrhea that may compromise the resident's nutritional intake or status. 1. Review of Resident #1's face sheet showed: -admitted to the facility on [DATE]; -[DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff dated 10/1/19 showed: -Alert and oriented and able to make decisions; -Feeds self independently; -Weight 141 pounds (lbs). Review of the dietary notes dated 10/24/19 showed: -The resident's current weight is 144 lbs. This is the same as last week. Will continue with weekly weights at this time. Review of the basic weight history report (a report used to monitor the residents weights) showed: -12/1/20 a weight of 141 pounds and on 4/21/20 a weight of 115 pounds. -A 26 pound weight loss in four months for a 18.44% weight loss. Review of the annual MDS dated [DATE] showed: -Alert and oriented and able to make decisions; -Feeds self independently -Weight of 174 lbs. Review of the dietary notes dated 12/18/19 showed: -Annual review, the resident's weight is 141 lbs. This is up one pound from last month. The residents weight six months ago was 158 lbs. At the time of the weight loss, his/her weight was monitored weekly and supplements were added to his/her diet for added calories. He/she is on a regular diet and is receiving a four ounce power shake with all meals. He/she is being weighed monthly and as needed (PRN). Will continue with current plan of care (POC). Review of the care plan for nutrition dated 1/13/20 showed: -Goal: continue to feed self and make own menu choices. Weight to remain stable and not lose five pounds or more over the next 90 days; -Approaches: Drink a supplemental shake two times a day (BID) for some added calories; Offer supplemental ice cream BID for added calories; continue to eat in room; honor food preferences, likes and dislikes; on a regular diet; weighed weekly due to recent weight loss and notify the doctor and responsible party of weight loss or gain. Review of the dietary notes dated 1/13/20 showed: -The resident's weight is 128 lbs. This is down 13 lbs from last month. He/she is on a regular diet and is receiving four ounces of power shakes with all meals and snacks BID, both for added calories related to history of poor meal intake and weight loss. Will place the resident on weekly weights at this time. Review of the basic weight history showed: -1/1/20-134 lbs; 2/2/20-132 lbs; 2/9/20-129 lbs; 2/15/20 -132 lbs; 2/23/20 -132 lbs; 3/1/20- 131 lbs; 3/10/20- 127 lbs; 3/15/20-126 lbs. Review of a fax communication sheet to the physician dated 3/16/20 showed: -Update on the resident's weight loss from 3/1/20 to 4/14/20: 131 lbs to 118 lbs. May we start the resident on Magic Cup (a high calorie ice cream supplement) BID and Mighty Shake (a high calorie ice cream shake supplement) BID for added calories? With orders to give the supplements signed by the physician on 4/20/20. Review of the quarterly MDS dated [DATE] showed: -Difficulty making decisions; -Feeds self independently; -Weight of 126 pounds. Review of the dietary note dated 3/25/20 showed: -The resident's current weight is 125 lbs. This is down one pound from last week. Will remain on weekly weights. Review of the fax communication sheet to the physician on 3/30/20 showed: -The resident has lost five pounds this week. The resident may need some Ensure or supplement of some kind. Note documented by the physician of: please monitor and report again next week. Review of the medical record showed no documentation of the physician notification of weights. Review of the basic weight history showed: -No weight documented from 3/15/20 to 4/4/20. Weight documented on 4/4/20 of 120 lbs; 4/14/20 of 118 lbs; 4/19/20 of 115 lbs; 4/21/20 of 115 lbs. Review of the fax communication to the physician on 4/23/30 showed: -The resident's weight on 3/1/20 was 131 lbs and on 4/14/20 the resident's weight was down to 118 lbs. The resident was started on Magic Cups BID and Mighty Shakes BID for added calories. The resident is not hardly drinking these. Could we get an order for [REDACTED]. Review of the care plan for nutrition showed no interventions for the prevention of the weight loss. Review of the medical record showed no documentation of meal intake or supplement intake. During an interview on 4/24/20 at 12:48 P.M., the resident's representative said: -He/she last saw the resident in early February and has not been able to visit the resident recently due to the recent COVID-19 restrictions; -He/she was not notified of the resident's significant weight loss until 4/23/20; -The resident has dementia and usually eats meals in his/her own room; -Often the resident is sleeping when his/her meal is delivered in the evening; -He/she has observed facility staff deliver the resident's meal to his/her room, place the tray in the resident's wheelchair and leave without assisting the resident in meal set up or offering encouragement to the resident for eating the meal; -The resident's weight is now 115 lbs. and that the resident's current weight is really small for him/her; -He/she feels that the facility should have notified him/her prior to 4/23/20 about the resident's significant weight loss. During an interview on 4/24/20 at 4:30 P.M. the resident said; -He/she used to be heavy, he/she has lost a lot of weight; -He/she does not like the food that is served; -He/she does not like the supplements that are given to him/her; -He/she likes ice cream. 2. Review of Resident #2's admission MD'S dated 11/11/19 showed: -Alert and oriented with difficulty making decisions; -Independent with eating; -Weight of 154 lbs; -[DIAGNOSES REDACTED]. four weeks; feed self in the dining room and make own food choices. Review of the basic weight history showed: -2/2/20 - weight of 161 lbs; 3/1/20 weight of 159 lbs; 4/4/20 weight of 151 lbs; 4/14/20 weight of 151 lbs; 4/18/20 weight of 149 lbs. -A 13 lb weight loss or a 8.07% weight loss in two months. Review of the medical record from 11/11/19 to 4/24/20 showed no documentation of food or fluid intake, no documentation of physician notification of the weight loss, no documentation from the dietary manager or registered dietician for the food consumption or weight loss. -The care plan showed no nutritional interventions for the weight loss or the prevention of weight loss. During an interview on 4/28/20 at 12:24 P.M., the Care Plan/MDS Coordinator said: -He/she began in the position in October 2019; -He/she reviews and updates resident care plans quarterly and annually, with any changes to the resident's condition or any changes to the resident's treatment plan; -Changes in any resident's condition or changes to resident treatment plans are communicated to him/her and to other departments in the weekly Risk meeting and in the communication meetings each morning; -Care plan strategies and goals are a collaborative effort across all disciplines and should be evaluated and updated if not improving the resident's outcomes. -Residents are weighed by the Restorative Aide as ordered by the Physician and reported to the MDS Coordinator; -He/she completes the weight variance reports for the facility and is aware of resident weight gains/losses; -He/she had not updated the resident care plan to include current strategies to prevent weight loss prior to 4/27/20; During an interview on 4/28/20 at 13:19 P.M., the Dietary Manager said: -He/she began his/her employment for the facility on 3/27/20, but has been a Dietary Manager employed in long-term care for approximately [AGE] years; -He/she has used nutritional intake forms to monitor resident intake in the past, he/she is unaware why this facility does not use them; -Dietary staff monitor resident consumption by observing trays being returned and dietary staff also receive notification verbally from nursing staff about changes in the resident's intake; -Resident #1 usually consumes approximately 25% of his/her food for both the morning and noon meals and prefers breakfast, pancakes, and sweets best; -Staff also prepares snacks to be delivered to the resident based on the resident's food preferences; -Resident #1's weight loss was discussed in the Risk meeting last week; -He/she recommended that Resident 1's nutritional supplements be changed to Mighty Shakes and Magic Cups twice daily as the current nutritional supplements were not successful in preventing resident weight loss. -Resident #1's physician was faxed the new supplement recommendation by nursing staff and the facility received a signed order from the physician for the recommended Mighty Shakes and Magic Cups twice daily on 4/20/20; -Resident #1's physician was faxed a second recommendation from nursing staff for Ensure nutritional supplements and the physician returned a signed order for Ensure nutrition supplements three times daily on 4/23/20; -He/she was unaware that a second recommendation had been faxed from nursing staff prior to receiving the signed order by the physician. During an interview on 4/28/20 at 1:37 P.M., Licensed Practical Nurse (LPN) A said: -He/she is aware of Resident #1's weight loss and the resident is having weight monitored weekly; -Resident #1 eats well some days but usually does not eat supper as the resident goes to bed very early, sometimes at three or four in the afternoon; -Nursing staff should monitor the resident's consumption when picking up hall trays, offer alternatives if the |

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| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 5)<br>food is not preferred by residents and notify dietary staff verbally of changes in the resident's intake; -The residents always have something on the snack cart available; -Resident #1 will eat a snack in the afternoon and gets ice cream as well; -He/she does not know how much the resident's have eaten at mealtime or snacks. During an interview on 4/28/20 at 3:27 P.M., LPN B said: -He/she is aware of Resident #1's significant weight loss; -Resident #1 is able to feed him/herself but requires a lot of encouragement from staff; -Dietary staff usually provide a snack at 9:00 A.M., 3:00 P.M. and 7:00 P.M. for the resident and the resident does well with ingesting snacks but does not usually consume full meals; -Resident #1 usually sleeps through evening meals; -He/she found a faxed order from Resident #1's Physician for nutritional supplements for weight loss; -He/she updated Resident #1's dietary orders and notified the dietary department; -He/she states he/she should have called his/her family with the new orders but did not call them; -He/she states that it is an expectation of nursing staff to notify the resident's family of changes in the resident's condition or changes in the treatment plan; During an interview on 4/30/20 at 10:42 A.M., the Registered Occupational Therapist (OTR) said: -The Occupational Therapy Aide (OTA), usually attends the weekly Risk meetings and was notified of the resident's weight loss on 4/23/20; -He/she evaluated Resident #1 for self-feeding concerns on 4/29/20; -Resident #1 will continue occupational therapy for his/her weight loss and for a decline in his/her ability to perform other ADL's related to recent fall. During an interview on 4/30/20 at 11:00 A.M., the Occupation Therapy Assistance (OTA) said: -He/she was notified of Resident #1's recent weight loss in the Risk meeting on 4/23/20; -He/she was unaware of Resident #1's weight loss and does not recall discussing the resident's weight loss in Risk meetings prior to 4/23/20; -He/she initially screened Resident #1, by observing the resident eating a meal, to determine the resident's appropriateness for therapy on 4/23/20; -He/she observed that Resident #1 was very distracted while eating at the nurse's station and the resident appeared to not like the food; During an interview on 4/30/20 at 2:30 P.M. the Administrator said: -He would expect the physician and responsible party to be notified when a resident has weight loss; -Supplements such as med pass, power shakes are not documented as given or consumed as these are considered snacks; -He would expect care plans to be updated as needed; -He would expect weights to be completed as ordered by the physician and documented in the computerized medical record. MO 9 |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br><br>Based on observation and interview the facility staff failed to maintain social distancing of themselves and the residents by staying 6 feet apart from each other and did not wear a facial mask in the facility to assist with preventing the spread of COVID-19. The facility census was 74. Review of the facility's COVID-19 policies and staff in-services dated 3/17/20, 3/23/20 and 4/22/20 showed the following efforts have been implemented to reduce the risk of COVID-19: -All employees and visitors will be required to wear a face mask at all times while providing cares, interactions between the staff and residents and while serving food. -Staff should practice social distancing. -Residents are limited to 10 residents per dining room. Review of the policies did not specify the social distancing of the residents while in the dining room. During an observation on 4/24/20 at 4:00 P.M. showed: -Two staff members standing two feet apart with no face masks on pushing a cart down the main hallway. Observation on 4/24/20 at 5:00 P.M. showed: -Five residents in the North hall dining room with two residents at a table with two feet separating the residents; -No residents wore masks. Observation on 4/24/20 at 5:15 P.M. showed: -Two card tables set up with two residents sat at each card table with less than two feet separating each resident in the dining area in the activity room. -No residents wore masks. Observation on 4/24/20 at 5:20 P.M. showed: -A dietary staff member standing at the steam table plating food with no mask on and a resident stood on the other side of the steam table with less than 2 feet separating the staff member and the resident. There was no barrier between the staff member and the resident. Observation on 4/20/20 at 5:30 P.M. showed: -Ten residents in the south hall dining room. Three round tables were set up with two residents sitting at each table with less than three feet separating the residents. One six foot table set up with four residents sitting at the table, two on each side of the table with less than two feet apart. No residents wore masks. Observation on 4/20/20 at 5:30 P.M. showed the Administrator in the south hall dining room with no face covering on. During an interview on 4/24/20 at 5:35 P.M. Licensed Practical Nurse (LPN) A said: -The residents can eat in the dining room, with two residents at a table with six feet separating each resident. The residents in the south hall dining room are not six feet apart; -All staff must wear a mask when they are around the residents. During an interview on 4/20/20 at 5:40 P.M. the Administrator said: -All staff must wear a mask when interacting with the residents; -Dietary staff are to wear masks when in the dining rooms; -The residents should be at least six feet apart when in the dining rooms. MO 9 |