STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOUGLAS COUNTY HEALTH CENTER	**4102 WOOLWORTH AVENUE OMAHA, NE 68105**

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 0554 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER NAC 175 12-006.05(16) Based on interviews, observation, record review and facility policy review, the facility failed to ensure one (Resident 114) of one sampled resident, who self-administered medications, was assessed to determine competency to do so, per the facility's policy and procedure. The facility also failed to ensure self-administered medications were stored in a locked drawer or medication cabinet per the facility's policy. Findings are: The facility's Self-Administered Medication policy and procedure documented: POLICY: Resident may be allowed, if clinically appropriate and if determined to be safe, to self-administer medications.Select medications may be kept in the resident room if stored in a locked drawer or locked medication cabinet.PROCEDURE: .2. In order to determine if a resident is capable of self-administration of medication, the nurse will complete an 'Evaluation for Self-Administration of Medication.' 3. If the Evaluation for Self-Administration of Medication indicates that the resident may safely administer medications, the resident may be allowed to self-administer select medications. 4. When the resident self-administers medication: *The resident must be competent and physically capable of providing the medication according to prescription and/or manufacturer's directions. *Pharmacy will set up or assist the resident in setting up the medications in a way that will allow the resident to safely self-administer medications (e.g. pill bottle, med administration cassette). *Pharmacy and/or nursing will instruct the resident on the safe self-administration of medications.Medications may be stored in the resident's room, only if they are kept in a locked drawer or locked medication cabinet.7. Nursing will (complete) an 'Evaluation for Self-Administration of Medication' for each resident, who self-administers medications with each MDS assessment and more frequently as needed to determine if the resident is still safe to self-administer medications and if this practice is clinically appropriate for the resident. Resident 114 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set, dated dated [DATE], documented the resident had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The assessment documented the resident was independent with most activities of daily living and had received antipsychotic, antidepressant and opioid medications on seven of seven days prior to the assessment date. The care plan, dated 12/10/19, documented: May use own meds (vitamins). The care plan did not address the facility's policy requirement for the completion of the Self Administration of Medications Assessment Tool, the procedure for medication self-administration and/or the requirement the medication would be kept in a locked drawer or medication cabinet. physician's orders [REDACTED]. A physician's orders [REDACTED]. On 07/27/20 at 10:56 AM, during an interview, the resident stated vitamins were in the bottom drawer of the bedside table. The resident opened the unlocked drawer and showed the surveyor bottles of [MEDICATION NAME], Vit E and B Complex. The resident stated (gender) self-administered the medication. On 07/28/20 at 1:12 PM, during an interview, Registered Nurse (RN)-A was asked about the bottles of medication in the unlocked bottom drawer in Resident 114's room. RN-A stated the physician had written an order to allow the resident to keep the medications at bedside. When asked if the facility's policy and procedure for self-administration of meds required the resident to be evaluated to determine if the resident was competent to self-administer medications, RN-A stated (gender) would have to look at the policy. On 07/29/20 at 10:35 AM, the Compliance Officer was asked if a self-administration of medications (SAM) assessment had been completed for the resident. The Compliance Officer stated the physician had written an order that the resident could self-administer medication. When asked if the facility's policy was followed to complete a SAM assessment for the resident and/or for the medication to be stored in a locked medication cabinet, the Compliance Officer stated the policy had not been followed. On 07/30/20 at 9:25 AM, the above findings were reviewed with the Administrator. When asked if the facility's policy and procedure had been followed to complete a SAM assessment and to store the resident's medications in a locked drawer or medication cabinet, the Administrator stated the policy had not been followed.
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER NAC 175 12-006.04C3a(6) Based on observation, record review and staff interview, the facility failed to ensure the physician for one (Resident 158) of 38 sampled residents was notified of a change of condition of significant weight loss. One hundred ninety-four residents resided in the facility. Resident 158 was admitted to the facility in 2013. [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) of 2, which indicated severe cognitive impairment, and had rejected care on 4-6 days during the 7 days prior to the assessment date. The MDS documented the resident required supervision with eating and required extensive assistance or was dependent upon staff for other activities of daily living (ADLs). The MDS documented the resident was 4 feet 8 inches tall, weighed 94 pounds, had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on a physician-prescribed weight-loss regimen. A dietary care plan, dated 04/01/20, documented the resident's Predicted Suboptimal Energy Intake related to [MEDICAL CONDITION] disorder and severe contractures. Appropriate goals and interventions to maintain/increase the resident's intake were addressed in the care plan. A nutritional assessment, dated 04/01/20, documented the resident weighed 94 pounds. The assessment documented the resident's ideal body weight was about 100 pounds. Resident 158's weight history was as follows: 09/2013 - 102 pounds, 09/2015 - 105 pounds, 09/2017 - 90 pounds, and 09/2019 - 126 pounds. The assessment documented in the significant weight change comment: (Resident weight is down 19 (pounds)/17% in the past month. Assuming accurate weight. Have asked for a re-weigh. And down 27 (pounds)/22% in the last 6 months. Under Unintentional Weight Change, the following was documented: Yes - (Weight) loss is off the highest weight (resident) had achieved here over past 7 years. The assessment documented the resident's meal pattern was 3 meals/day, appetite was fair, and intake was 50%. The assessment documented the resident's supplement type was Strawberry Boost HP, Ensure [MEDICATION NAME] (breakfast, lunch, and dinner) and Magic Cup (lunch). The Summary documented: Intake is down (new average intake about 40%. And there has been significant weight loss. Have asked for a re-weigh on this morning's weight, but based on it (and the last four months (resident) has been trending down-albeit off (gender) highest recorded weighs in the about 7 years (gender) has resided here) (gender) weight is down 17% in the past month and 22% the last 6 months, both are significant losses. The assessment documented the resident received a regular diet with double portion size per the patient request. It documented the resident received a soft diet and Ensure [MEDICATION NAME] and Magic Cup for supplements. The annual MDS, dated [DATE], documented the resident had a BIMS of 00, which indicated the resident had severe cognitive impairment, and had rejected care on 4-6 days during the 7 days prior to the assessment date. The MDS documented the resident required supervision with eating and was dependent upon staff for all other ADLs. The MDS documented the resident was 4 ft 8 inches tall, weighed 98 pounds, and had experienced weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss

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 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) regimen. The Nutritional Status Care Area Assessment (CAA) Summary, dated 06/29/20, written by a registered dietician (RD)-A, documented: (Resident) triggers the CAA secondary to significant weight loss over the past 6 months and due to the use of mechanically altered diet. Current diet is Soft. (Resident's) weight is down 28 (pounds) over the past 6 months. This weight loss comes after the (resident) had reached (gender) highest weight since admission here (126 (pounds)). (Gender) remains well above (gender) lowest weight while residing here of 72 (pounds). And in fact, (resident) is up five (pounds) over the past one month. Currently (gender) does appear to be eating more again now.(Gender) does remain at nutritional risk and care plan will continue for predicted suboptimal intake. Weight records for Resident 158, documented the resident's weights were as follows: 12/2019: 126 pounds 01/2020: 122 pounds 02/2020: 119 pounds 03/2020: 113 pounds - a 5.04% loss in 30 days 04/2020: 94 pounds - a 16.81% loss in 30 days and a 22.95% loss in 90 days 05/2020: 93 pounds - a 21.84% loss in 90 days 06/2020: 98 pounds - a 13.27% loss in 90 days and a 19.67% loss in 180 days 07/2020: 97 pounds - a 20.49% loss in 180 days A nutritional assessment, dated 06/29/20 at 9:04 AM, by RD-A, documented the resident's weight is down 22% in the past 6 (months). The assessment documented the weight loss was unintentional. The assessment documented the resident's intake was 75% and ate 3 meals per day. Supplements were provided 3 times/daily and included Strawberry Boost HP, Ensure [MEDICATION NAME] BLD, and Magic Cup-L. The assessment summary documented: Res intake has been down until this past month, when it has inproved (sic) and res has gained back 5 (pounds) of the weight (gender) recently lost. Continuing supplement at each meal. Intake does vary with the supplement, from taking most of it, to refusing it, depending on (gender) mood. Meal intake documentation was reviewed back to 04/01/20. The resident's meal intakes were routinely recorded in the electronic health record (EHR). No documentation could be located in the EHR which indicated the physician had been notified since the resident's significant/severe weight loss began on 03/01/20. On 07/27/20 at 12:37 PM, Resident 158 was observed in the room eating lunch. The resident was feeding (gender) without difficulty and had eaten most of the meal (cottage cheese and tomato soup). On 07/30/20 at 11:55 PM, the Administrator provided documentation the physician had been notified of the resident's weight loss on 06/29/20. The above listed time frames of significant weight loss were reviewed with the Administrator. When asked if the significant/severe weight losses for the resident constituted a significant change in condition for which the physician should have been notified, the Administrator stated the physician had not been notified until 06/29/20 and should have been notified earlier.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and facility policy review, the facility failed to screen prospective employees by not providing reference checks on 5 of 13 (RN-C, CNA-A, CNA-B, Admin Medical-A and Security Guard-A) employee files reviewed. The facility's census was 194. Findings are: A review of the facility's Abuse policy, revised on 08/18, read in part, Applicants who have been given conditional offer of employment will be screened prior to employment for a history of abuse, neglect or mistreatment of [REDACTED]. the facility's employee files revealed that 5 of 13 (RN-C, CNA-A, CNA-B, Admin Medical-A and Security Guard-A) employee files reviewed, did not have reference checks provided. On 07/29/20 at 10:37 AM, the Human Resources (HR) Specialist stated the facility had stopped doing reference checks on prospective employees because when the facility mailed or called for reference checks, the facility did not get a response. The HR Specialist further stated the facility had not been doing the reference checks since 2017 and the former HR Director decided 13 that the facility should stop doing reference checks. On 07/29/20 at 12:55 PM, the Administrator stated HR was responsible for the Nurse Aid Registry employees, but the department heads complete their own reference checks. The Administrator was not aware that the reference checks were not being done and that it affected approximately 1/3 of the employees at the facility.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** LICENSURE REFERENCE NUMBER NAC 175 12-006.17 Based on observation, interview, and policy review, the facility failed to ensure proper infection control protocol was used to prevent the spread of infection during the administration of medication via a feeding tube. This affected one (Resident 136) of one sampled resident for whom the administration of medications via feeding tube was observed. Findings are: The facility's policy for Administration of Medications via a Feeding Tube, not dated, did not address proper infection control protocol to place equipment on a clean barrier. On 07/28/20 at 11:50 AM, Licensed Practical Nurse (LPN)-A was observed as she administered medications via feeding tube to Resident 136. The LPN used a 60-milliliter syringe to check for placement of the feeding tube. She then removed the plunger from the syringe and set it on the bed next to the resident. She did not set the plunger onto a clean barrier. On 07/28/20 at 12:03 PM, Registered Nurse (RN)-B, who was assisting the LPN with the medication administration, was asked if the plunger should have been set onto a clean barrier instead of onto the bed. She stated, Yes. The LPN stated she did not remember setting the syringe plunger onto the bed. On 07/29/20 at 4:51 PM, the Administrator was informed of the above observation of the plunger being placed on the bed beside the resident. She acknowledged the findings and stated the plunger should have been placed on a clean barrier.