STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265857	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIBERTY HEALTH & WELLNESS	2201 GLENN HENDREN DR LIBERTY, MO 64068

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff invoked (activated by verifying incapacity of the resident to make decisions) Durable Powers of Attorney for healthcare (DPOA-names an agent to make decisions for the resident) prior to allowing the designated agent to make healthcare decisions or sign Outside of Hospital Do Not Resuscitate (OHDNR) forms, and failed to ensure residents' care plans and medical records reflected the same code status (Full Code or DNR). This affected five out of 18 sampled residents (Residents #7, #42 #56, #58, and #69). The facility census was 81. Review of Missouri Revised Statute 404.825, related to Durable Power of Attorney, showed: Unless the patient expressly authorizes otherwise in the power of attorney, the powers and duties of the attorney in fact to make health care decisions shall commence upon a certification by two licensed physicians based upon an examination of the patient that the patient is incapacitated and will continue to be incapacitated for the period of time during which treatment decisions will be required and the powers and duties shall cease upon certification that the patient is no longer incapacitated. One of the certifying physicians may be the patient's attending physician. There certification shall be made according to accepted medial standards. The determination of incapacity shall be periodically reviewed by the attending physician. The certification shall be incorporated in the the medical records and shall set forth the facts upon which the determination of incapacity is based and the expected duration of the incapacity. Other provisions of this section to the contrary notwithstanding, certification of incapacity by at least one physician is required. 1. Review of Resident #56's Healthcare Treatment Directive (HCD) and Durable Power of Attorney (DPOA) for healthcare decisions form, dated 1/20/12, showed: -The resident named Family Member (FM) A as an agent to make healthcare decisions. -Authority to make decisions for the resident is effective when and only when I cannot make my own healthcare decisions. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/23/19, showed the resident's brief interview of mental status score (BIMS) was 15 (13-15 is considered cognitively intact). Review of the resident's Outside the Hospital Do Not Resuscitate (OHDNR) form, showed FM A signed it on 11/13/19, and the physician signed it on 11/27/19. Review of the resident's quarterly MDS, dated [DATE], showed the resident's BIMS was 13. Review of the resident's care plan, initiated on 2/22/20, showed: -Had a DNR code status; -Advance directive and the resident wishes will be honored; -Completed a DNR and medical power of attorney; -Physician will be notified of the resident's wishes and any needed physician's orders [REDACTED]. status was a Full Code. Review of the resident's medical record showed staff did not obtain a verification of incapacity, signed by two physicians, prior to allowing FM A to sign the resident's OHDNR, or to have the resident sign his/her own OHDNR, if he/she remained competent to do so. During an interview on 3/13/20, at 3:23 P.M., the Director of Nurses (DON) said: -This was one of the advance directives identified in a facility audit as an issue. -The DPOA signed the DNR, but a verification of incapacity was not done prior to the signing, so facility staff identified that the DNR was not valid, changed the resident's code status to a Full Code, and began interventions to correct it. -The MDS coordinator needed to change the care plan to reflect the code status change to a Full Code until they put the proper paperwork in place to validate a DNR status. 2. Review of Resident #7's annual MDS, dated [DATE], showed: - A BIMS score of 8, indicating moderate cognitive impairment; - Limited assistance with all activities of daily living (ADLs); - [DIAGNOSES REDACTED]. Review of the resident's Health Care Declaration and DPOAHC showed the resident named two agents to make decisions for him/her when he/she no longer could; - Signed by the resident on 9/12/12. Review of the resident's OHDNR showed one of his/her agents signed the form on 9/26/19. Review of the resident's care plan, edited on 12/17/19, showed: - Advanced directive/code stauts: Full Code; - Approach start date: 11/14/18: has a living will and medical/financial power of attorney; did not indicate Full Code in the blank for staff to mark this. Review of the resident's Electronic Medical Record (E-MR) showed: - The demographics page indicated the resident as a DNR; - The physician's orders [REDACTED]. Review of the facility's Final DNR/DPOA Audit, dated 3/2/20, showed: - The audit included Resident #7; - Under the column Full Code staff left this blank; - DNR staff marked an X; - DPOA staff marked Yes; - Invoked staff marked No - Notes staff wrote Guardian ? 3. Review of Resident #58's OHDNR showed the resident did not sign the form. A family member signed the form on 11/30/16, and wrote DPOA out to the side of the signature. Review of the resident's quarterly MDS, dated [DATE], showed: - A BIMS score of 3, indicated severe cognitve impairment; - [DIAGNOSES REDACTED]. [REDACTED]. Review of the resident's care plan, initaited on 2/23/20, showed: - DNR code status; - Advanced directive and resident wishes will be honored; - Marked an X under DNR. Review of the Final DNR/DPOA Audit, dated 3/2/20, showed: - The audit included Resident #58; - Under the column Full Code staff left this blank; - DNR staff marked an X; - DPOA staff marked No; - Invoked staff marked No - Notes staff wrote PCC (Point-Click-Care, the facility's E-MR system) notated POA, not on file, DNR signed by DPOA. Review of the Physician's Certification of Incapacity to Make an Informed Decision showed: - One physician signed the form on 3/4/20; - A second physician signed the form on 3/11/20. Review of the resident's E-MR on 3/13/20, showed: - Demographics listed a responsible party with a relationship status of other; - The contact type indicated that the responsible party was the power of attorney for financial and care; - Advanced directive: DNR. Review of the resident's medical record showed no DPOA paperwork for the resident giving the person listed as his/her responsible party authority to make end-of-life decisions. 4. Review of Resident # 42's MDS, dated [DATE], showed: - Unable to make daily decisions; - On Hospice care. Review of the the residents medical record showed: - The resident is a full code; - The resident appointed his/her daughter as agent for durable power of attorney; - The daughter signed paper work for the resident to be placed on Hospice; - There were no certification of incapacitation forms signed by physicians in the medical record. 5. Review of Resident #69's MDS, dated [DATE], showed: - Moderately impaired decision making skills; - On Hospice care. Review of the resident's medical record showed: - The resident appointed his/her spouse as agent for Durable Power of Attorney; - An outside the hospital do not resuscitate form signed by the resident's spouse on 1/22/20. - There were no certification of incapacitation forms signed by physicians in the medical record. 6. During an interview on 3/12/20, at 4:30 P.M., the DON said they had identified code status as an issue they needed to correct. They had been auditing all medical records and working to get letters of incapacity for those residents with DPOA paperwork and having residents' responsible parties sign a new OHDNR after the DPOA had been invoked. If a resident's DPOA had not yet been invoked, he/she should have been made a full code. She thought social services had updated PCC so that it matched the resident's true code status. If they did not have DPOA paperwork in

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) the facility, those residents should be a full code until the true DPOA could be determined. A resident should not be enrolled in hospice by someone who was not the DPOA and not until the DPOA had been invoked. MO 0
F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on interview and record review, the facility failed to inform two of three sampled residents (Resident #134 and #135) for Beneficiary Protection Notifications when the facility discharged them from skilled nursing services and ended their Medicare coverage before they had exhausted their benefit days. The facility had a census of 81. 1. Review of Resident #134's Skilled Nursing Facility (SNF) Beneficiary Protection Notification Review, completed by facility staff, showed: - Medicare Part A skilled services episode start date: 1/23/20; - Last covered day of Part A services: 2/16/20; - The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted; - Staff marked the did not provide the Notice of Medicare Non-Coverage (NOMNC) to the resident and marked to indicate they could not locate the form. 2. Review of Resident #135's SNF Beneficiary Protection Notification Review, completed by facility staff, showed: - Medicare Part A skilled services episode start date: 11/12/19; - Last covered day of Part A services: 12/5/15; - The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted; - Staff marked the did not provide the NOMNC to the resident and marked to indicate they could not locate the form. During an interview on 3/11/20, at 11:36 A.M., with the Social Services Director: - They could not locate the documentation for either resident.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff provided transfer or discharge notification to residents and their responsible party and the reasons for the transfer/discharge in writing in a language they understood. This affected three of 18 sampled residents (Residents #6, #81 and #83). The facility census was 81. Review of the policy related to discharging residents, dated December 2016, showed: - The purpose of this procedure is to provide guidelines for the discharge process. - The resident should be consulted about the discharge. - If discharging the resident to another long-term care facility, tell the resident where it is located, any information you can about the facility (size, services, what it looks like, etc.), who will be providing the resident's care, that his/her family and visitors will be informed of the discharge and location, and why the discharge is necessary. - If discharging the resident to the hospital or another facility, ensure a transfer summary is completed and a telphone report is called to the receiving facility. - The policy did not include provision of a written notice of discharge to the resident and the resident's representative. 1. Review of Resident #81's medical record showed: - Date of admission [DATE]; - The resident discharged to another facility on [DATE]; - A notice of discharge was not in the resident's record or documentation regarding a notice of discharge being provided to the resident or representative. During an interview on 3/11/20 at 4:19 P.M., Medical Records staff said: - The resident had some issues while at the facility and they had to discharge the resident to another facility; - He/she was not sure if there was any discharge notice provided to the resident; - The previous Administrator and previous Social Services Director (SSD) worked on getting the resident discharged ; - The SSD at the time of the resident's discharge was no longer in the position but still worked at the facility. During an interview on 3/13/20 at 11:37 A.M., the previous SSD said: - He/she thought he/she had just stepped in to the role as SSD when the resident discharged ; - He/she did not write a discharge letter for the resident but he/she was not saying the previous Administrator did not give the resident a discharge notice but did not know where that information would be; - The discharge happened very fast, like an emergency discharge. During an interview on 3/13/20 at 12:30 P.M., Minimum Data Set (MDS) Coordinator said they could not find a notice of discharge in the resident's record. 2. Review of Resident #83's MDS entries, a federally mandated assessment instrument completed by facility staff, showed: -[DATE]-Entered from an acute care hospital; -[DATE]-discharged to an acute care hospital. Review of the resident's nursing progress notes, dated [DATE], showed the resident developed chest pain and staff sent him/her to the hospital. Review of the resident's medical record showed staff did not indicate they sent a written discharge notice to the resident and the resident representative. 3. Review of Resident #81's medical record showed: - Date of admission [DATE]; - The resident discharged to an acute care hospital on [DATE]; - A notice of discharge was not in the resident's record or documentation regarding a notice of discharge being provided to the resident or representative. 4. During an interview on 3/13/20, at 3:47 P.M., the administrator said he/she discovered that staff did not send written notices of discharge to residents and their representatives after January 2020. MO 2
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** Based on interview and record review, the facility failed to inform the resident and the resident's family/legal representative of the facility's bed-hold policy at the time of transfer/discharge to the hospital for two of 18 sampled residents (Residents #83 and #6). The facility census was 81. Review of the policy related to discharging residents, dated December 2016, showed: - The purpose of this procedure is to provide guidelines for the discharge process. - The resident should be consulted about the discharge. - If discharging the resident to the hospital or another facility, ensure a transfer summary is completed and a telphone report is called to the receiving facility. - The policy did not include provision of a written bed-hold policy notification to the resident and the resident's representative. 1. Review of Resident #83's Minimum Data Set (MDS) entries, a federally mandated assessment instrument completed by facility staff, showed: -[DATE]-Entered from an acute care hospital; -[DATE]-discharged to an acute care hospital. Review of the resident's nursing progress notes, dated [DATE], showed the resident developed chest pain and staff sent him/her to the hospital. Review of the resident's medical record showed staff did not document to indicate they provided a bed-hold policy notification to the resident and the resident representative. 2. Review of Resident #6's nurse's progress notes showed the resident fell three times on [DATE] and was sent to an acute care hospital. Review of the resident's medical record showed staff did not document that they provided a bed-hold policy notification to the resident and the resident representative. 3. During an interview on 3/13/20, at 3:47 P.M., the administrator said he/she discovered that staff did not provide bed-hold policy notifications to residents and their representatives after January 2020.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to assure staff used the comprehensive assessment to develop, implement and review a comprehensive person-centered plan of care consistent with the resident rights that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, and psychosocial needs for two of 18 sampled residents (Resident #22 and #38). The facility census was 81. 1. Review of Resident #22's care plan, edited 10/16/19, showed the plan did not direct staff about the resident's showers. Review of the resident's Minimum Data Set (MDS) a federally mandated assessment instrument completed by facility staff, dated 1/13/20, showed: - Able to make daily decisions; - Dependent on staff for bathing. Review of shower sheets provided by facility

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) showed staff had not documented they gave the resident a shower since 12/18/19. During an interview on 3/10/20 at 3:01 P.M., the resident said: - One of his/her biggest concerns with the facility was that he/she did not get showers regularly; - He/she had always considered him/herself a very clean person; - It had been very difficult to come to terms with be allowed only two showers a week; - It was so upsetting that now he/she only got one shower every other week; - Actually had not had a shower at all so far this month. During an interview on 3/13/20 at 8:01 A.M., the Director of Nurses said; - The resident's preferences related to showers should be included in the care plan. 2. Review of Resident #38's admission MDS, dated [DATE], showed: -[DIAGNOSES REDACTED]. Observation on 3/10/20, showed the resident received oxygen at 2 liters (L.) per nasal cannula via an oxygen concentrator. Observation on 3/12/20 at 9:14 A.M., showed the resident lay in bed with oxygen on at 2 L./nasal cannula. Review of the resident's care plan, revised on 3/12/20, showed the plan did not include any information related to oxygen therapy. Review of the resident's active physician orders, as of 3/12/20, did not include any orders for oxygen. During an interview on 3/13/20, at 2:44 P.M., the MDS Coordinator said that if a resident received oxygen therapy, it should be included in their care plan.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff provided care to meet the professional standards of quality when they failed to obtain a physician's order for oxygen for one of 18 sampled residents (Resident #38); failed to provide care and services per physician order for [REDACTED]. The facility census was 81. 1. Review of the manufacturer's guidelines for Inveltys (medicated eye drop for post surgery) and Simbrinza (medicated eye drop for [MEDICAL CONDITION]) eye drops showed: - Shake before using. Review of www.drugs.com for Simbrinza showed - Shake the eye drops well just before each use: - Close your eyes for 2 or 3 minutes with your head tipped down, without blinking or squinting. Gently press your finger to the inside corner of the eye for about 1 minute, to keep the liquid from draining into your tear duct. Review of www.drugs.com for Inveltys showed: - Shake well before use. - After use, keep your eyes closed. Put pressure on the inside corner of the eye. Do this for 1 to 2 minutes. This keeps the drug in your eye. Review of www.drugs.com for [MEDICATION NAME] (nasal spray used to treat seasonal allergies [REDACTED]. 2. Review of Resident #2's active March, 2020 physician order sheet (POS) showed the physician ordered: - [MEDICATION NAME] Suspension 50 micrograms (mcg/Act) Actuation; - Spray in nostril two times a day for seasonal allergies [REDACTED].M., showed Certified Medication Technician (CMT) B asked the resident to blow his/her nose while he/she washed his/her hands. Without shaking the nasal spray, CNA B pumped (actuated) the nasal spray into each nostril. 3. Review of Resident #67's active March, 2020 POS showed the physician ordered: - Inveltya Suspension 1% instill one drop in right eye two times a day; - Simbrinza Suspension 1-0.2 %. instill one drop in left eye two times a day. Observation on 3/12/20 at 9:56 A.M., showed CMT B without shaking the Inveltya, instilled one drop into the right eye and applied pressure on the inner corner of the eye for 30 seconds. At 9:57 A.M., CMT B without shaking the Simbrinza, instilled one drop into the left eye and applied pressure for 30 seconds to the inner corner of the eye. 4. During an interview on 3/13/20 at 11:42 A.M., CMT B said; - He/she should have shaken the nasal spray before he/she administered it to the resident; - He/she should have shaken the medicated eye drops before he/she administered them; - The resident probably blew what he/she inhaled back out; - There were more residents who puffed their inhaler the same way, but he/she should have told him/her only take one inhalation. 5. Review of Resident #49's active March, 2020 POS, showed the physician ordered: - [MEDICATION NAME] Solution Pen-injector 100 units/millilters (ml); Inject 20 units twice a day for diabetes mellitus; - [MEDICATION NAME] Solution Cartridge 100 units/ml; Inject per sliding scale; - The POS does not direct staff how often to complete accuchecks for the sliding scale [MED]. Observation on 3/11/20 at 7:58 A.M., showed Licensed Practical Nurse (LPN) B completed accuchecks on the resident, retrieved the resident's two [MED] pens from his/her medication carts and without cleaning the ports, applied new needles on the pens, primed each pen and administered the [MED]. During an interview on 3/12/20 at 2:23 P.M., LPN B said: - He/she should wipe the [MED] pen ports with an alcohol wipe. 6. Review of Resident #11's active March, 2020 POS and care plan, dated 2/22/20, showed: - Resident may have low air loss mattress to promote and maintain skin integrity; - Care plan directed staff, low air loss mattress to be inflated based upon the current weight of the resident. Review of the resident's electronic medical record (E-MR showed his/her current weight as of 3/4/20, as 134.6 pounds. Observations on 3/10/20 at 10:48 A.M., 3/12/20 at 10:26 A.M., and 3/13/20 at 8:23 A.M., showed the resident lay on a low air loss mattress. The low air loss mattress was set to nine. Observation of the motor showed the number nine setting is for a weight of 350 pounds. 7. Review of the facility's oxygen administration policy, dated October 2010, showed: - Verify that there is a physician's order for this procedure and review the order or facility protocol for oxygen administration. - Unless ordered otherwise, start the oxygen flow rate at 2-3 liters (L) per minute. Review of Resident #38's admission MDS, dated [DATE], showed: -[DIAGNOSES REDACTED]. Observation on 3/10/20, showed the resident received oxygen at 2 L per nasal cannula via an oxygen concentrator. Observation on 3/12/20, at 9:14 A.M., showed the resident lay in bed with oxygen on at 2 L per nasal cannula. Review of the resident's care plan, revised on 3/12/20, showed staff did not include any information related to oxygen therapy. Review of the resident's active physician orders, as of 3/12/20, showed the orders did not include any orders for oxygen. 7. During an interview on 3/13/20 at 8:01 A.M., the Director of Nurses (DON) said: - She expected staff to clean the ports of [MED] pens with alcohol wiped before they applied a new needle; - She expected staff to follow manufacturer's guidelines for medicated eye drops, nasal sprays and inhalers; - She expected staff to follow physician orders and care plan interventions; - If the low air loss mattress was to be set in conjunction with the resident's weight, the setting should be as near the resident's actual weight as possible; - Staff should check the setting on the low air loss mattress every shift.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** Based on interview and closed record review, the facility failed to ensure staff completed a comprehensive discharge summary for one of three sampled closed records (Resident #81) to include appropriate information about the resident's diagnoses, course of illness/treatment or therapy, a post-discharge plan of care to assist the resident to adjust to his/her new living environment when applicable. The facility census was 81. Review of a facility policy titled Discharge Summary and Plan, dated December 2016, included the following: - When a resident's discharge is anticipated, a discharge summary and post-discharge plan will be developed to assist the resident to adjust to his/her new living environment; - The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. - A copy of the following will be provided to the resident and receiving facility and a copy will be filed in the resident's medical records: o An evaluation of the resident's discharge needs; o The post discharge plan; and o The discharge summary. 1. Review of Resident #81's medical record showed: - Date of admission [DATE]; - The resident discharged to another facility on [DATE]; - The resident had documentation in his/her record titled Discharge-Interdisciplinary Discharge Summary that was incomplete. It did not include the required information for a recap of the resident's stay at the facility. During an interview on 3/11/20 at 4:19 P.M., Medical Records staff said nurses and the Social Services Director (SSD) completed discharge summaries. The SSD at the time of the resident's discharge was no longer in the position but still worked at the facility. During an interview on 3/13/20 at 11:37 A.M., the previous SSD said: - He/she thought he/she had just stepped in to the role as SSD when the resident discharged ; - The discharge happened very fast, like an emergency discharge; - He/she was never trained on how to complete the discharge summary.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff provided complete perineal care for

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) dependent residents, which affected two out of 18 sampled residents (Residents #11 and #69), and failed to ensure residents received baths/showers as scheduled or according to their preferences, which affected three sampled residents (Residents #30, #40 and #73). The facility census was 81. Review of the facility's Bath and Shower policy, revised 2/18, showed: - To promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin; - Document date and time shower was performed,who assisted the resident with the shower, all assessment data; - If the resident refused the shower, document why and the intervention taken; - The signature and title of the person recording data. 1. During a group resident interview on 3/11/20, at 2:06 P.M., residents said: -They should receive baths/showers twice a week, but they sometimes did not receive a bath/shower for two to three weeks. -Eleven out of 24 residents present said they did not receive at least two baths/showers a week. -When residents notify staff that they have not received their scheduled baths/showers, staff tell them that the assigned bath aide did not show up, or was pulled to do other things. -The shower aide should not be assigned other duties. -They have no option to receive a bath/shower any more than two times a week. 2. Review of Resident #40's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/22/20, showed: -Cognitively intact; -Required supervision and set up assistance for toilet use; -Independent for transfers, personal hygiene and bathing. Review of the resident's care plan, revised on 1/28/20, showed: -Requires assistance to safely meet activities of daily living (ADL's); -At risk for bowel and bladder incontinence due to mobility and receives multiple bowel medications; -Provide incontinence care after each incontinent episode; -Did not address bathing needs or preferences. Review of the resident's January 2020 bathing documentation showed the resident received a bath/shower four times and refused once. Review of the resident's February 2020 bathing documentation showed the resident received a bath/shower two times, and three times staff documented that the resident wanted to wait until the next day. Review of the resident's March 2020 bathing documentation, as of 3/12/20, showed the resident received one bath/shower so far this month. During an interview on 3/11/20, at 2:08 P.M., the resident said: -He/she should receive a shower twice a week, but he/she only got them about every two to three weeks. -The staff that provided baths/showers either did not show up, or was pulled to do other things. -It should be a priority to allow staff assigned to do baths/showers to complete them, otherwise they get too far behind to catch up. 3. Review of Resident #30's admission MDS, dated [DATE], showed: -admitted on [DATE]; -Moderate cognitive impairment related to decision-making skills; -Required extensive assistance for transfers and toilet use; -Always incontinent of bladder; -Received no bath/shower during the entire seven-day look-back period. Review of the resident's care plan, revised on 1/29/20, showed: -Impaired urinary elimination related to [MEDICAL CONDITION] and not always knowing the need to void; -Assist with toileting and provide incontinence care after each incontinent episode; -Keep as clean an dry as possible; -Did not specifically address the resident's bathing needs or preferences. Review of the resident's January 2020 bath/shower documentation showed the resident refused a bath/shower on 1/30/20 and no other documentation that staff provided or offered other baths/showers. Review of the resident's February 2020 bath/shower documentation showed the resident received a bath/shower on [DATE] and 2/27/20, and refused a bath/shower on [DATE] due to illness. Staff provided no bathing documentation for March 2020, as of 3/12/20. 4. Review of Resident #73's MDS tracking information showed the resident was discharged on [DATE] and returned on 2/10/20. Review of the resident's annual MDS, dated [DATE], showed: -Extensive assistance required for transfers and toilet use; -Had a urinary catheter (sterile tube inserted into the bladder to drain urine); -Frequently incontinent of bowel; -Total dependence on staff for bathing. Review of the resident's care plan, dated 2/13/20, showed: -Moderate cognitive impairment for decision-making; -Had a urinary catheter; -Had bowel incontinence; -Had an ADL self care deficit related to left-sided weakness after a stroke; -Totally dependent on staff for bathing-able to use grab bars to transfer from wheelchair to shower chair; -Did not address any bathing preferences. Review of the resident's February 2020 bath/shower documentation showed the resident received baths/showers six out of eight opportunities. Review of the resident's March 2020 bath/shower documentation showed the resident received a bath/shower on 3/10/20. 5. During an interview on 3/13/20, at 8:01 A.M., the Director of Nurses (DON) said: -Residents generally receive two showers a week, but may have them more often if they want. -If the shower aide does not show up, then someone else should do the showers. -The facility did have two shower aides. -She thought one shower aide was ill, but that someone was filling in for that person. 6. Review of the facility policy for Perineal Care, revised February 2018, showed: - Wash the perineal area, wiping front to back; - Separate perineal folds and wash downward front to back; - Continue to wash the perineum moving from inside outward to the thighs 7. Review of Resident #11's MDS, dated [DATE], showed: - Severely impaired decision making skills; - Dependent on staff for toilet use and personal hygiene; - Always incontinent of urine and fecal material. Review of the resident's care plan, edited [DATE], showed: - Keep clean and dry as possible; - Provide incontinence care after each incontinent episode. Observation on 3/12/20 at 10:25 A.M., showed Certified Nurse Aide (CNA) B and CNA C transferred the resident to bed and provided peri care. The resident was incontinent of a small amount of urine. CNA C did the following: - Assisted CNA B to remove the resident's pants and unfasten his/her brief; - CNA C used a pre-moistened wipe to clean the right groin and another wipe to clean the left groin; - Assisted CNA B roll the resident to his/her side; - Wiped with different pre-moistened wipes once from the rectum to the coccyx, one hand width on the right buttock, and with the third wipe, wiped one hand width on the left buttock and from the rectum to the coccyx with that same wipe. - CNA C did not clean any perineal fold, pubis area or between the inner legs. 8. Review of Resident #69's MDS, dated [DATE], showed: - Moderately impaired decision making skills; - Resident had no toilet use and only received personal hygiene once or twice; - Always incontinent of urine and fecal material. Review of the resident's care plan, edited on 2/9/20, showed: - Clean perineal area with each incontinent episode. Observation on 3/12/20 at 10:01 A.M., showed CNA C used a gait belt and transferred the resident to bed then provided peri care. CNA C did the following: - Rolled the resident and pulled down the resident's pants and brief; - Sprayed peri wash on to pre-moistened wipes; - With the first wipe, CNA C wiped down the right groin and halfway down on the left groin; - CNA C used the second wipe and re-wiped the right groin; - He/she cleaned the left groin with the third wipe, then assisted the resident to roll over; - CNA C wiped one hand width on the left buttock and used the same wipe to wipe once from rectum to coccyx CNA C placed a clean brief under the resident. 9. During an interview on 3/12/20 CNA C said: - He/she should wipe front to back; - Wipe once down the inner leg in the private area. If dirty use more than one wipe, if not so dirty, use one wipe; - Roll the resident to me, wipe the buttocks and between the legs if dirty. During an interview on 3/13/20 at 8:01 A.M., the Director of Nursing said: - Staff should clean more than down the groin area; - Staff should separate and clean all skin folds that could have come in contact with urine and feces; - Staff should continue to clean until wipes re-clean after wiping the residents.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to monitor and reduce the possibility of accidents and injuries when they moved residents to a hall without staff assigned to monitor the call lights. The call lights sounded at an unstaffed nurses' station on the corner of the 200 and 300 halls, where no staff worked. As a result of this one of 18 sampled residents (Resident #6) experienced multiple falls throughout one day, the first resulted in the resident lying on the floor for an extended period of time hollering for help while the call light of his/her next door neighbor, who heard him/her hollering, went unanswered. The resident experienced a [MEDICATION NAME] spine fracture as a result of the fall. Staff also failed to monitor residents (Resident # 23, #26, #50 and #62) who smoked at a smoke free facility. The facility census was 81. 1. Review of Resident #6's MDS, dated [DATE], showed: - Slightly impaired decision-making skills; - Required supervision with walking; - No falls last 30 days. Review of the resident's new replacement fall care plan, put in place [DATE], showed: - Resident has had an actual fall; - Will resume usual activities without further incident; - Educated use of walker and call light when needing assistance; - For no apparent, acute injury, determine and address causative factors of fall; - Monitor, document and report as needed for 72 hours to physician signs and symptoms of pain, bruises, change in mental status. New onset confusion, sleepiness, inability to maintain posture or agitation; - Neuro checks for 72 hours; - Obtain urinalysis test after 2nd fall. Review of the resident's electronic medical record (E-MAR) showed the resident was admitted to the facility on [DATE]. Review of the resident's active March, 2020, physician order [REDACTED]. Review of the nurse's note, dated [DATE] at 3:00 A.M., showed a late entry: - Was notified by staff caregiver that he/she was taking out trash and saw the resident's neighbor's light on; - In response

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) he/she was informed that the resident next door had been calling for help. - Upon entering the room, resident was laying on the floor outside the restroom door on his/her right side wearing only a gown and no footwear. - He/she was able to reach a blanket for cover and towel a towel between legs for urination. - A large contusion was above his/her left forehead. - He/she verbalized with clear speech, he/she was reaching for something and fell forward hitting his/her head. - Does not recall if he/she was unconscious. - He/she was evaluated for head and neck trauma. - Range of motion to arms, legs, hips and hands. - He/she was then assisted into a wheelchair with four staff and reassessed for future possible injuries; - Vital signs and neuro checks immediately started. - The head of bed was elevated with a cool compress across forehead. - He/she denied pain, however accepted two 325 milligram (mg) Tylenol. - No answer to phone call to daughter. - A brief message was left to call facility for questions or concerns. - Facility physician was faxed and office manager made aware. Review of the facility's Unwitnessed Incident Investigation, for the [DATE] - 3:00 A.M., nurse's note showed the nurse noted resident with a hematoma to the left forehead. Injuries observed at time of incident, the nurse noted: No injuries at time of incident. Review of a handwritten note from Certified Nurse Aide (CNA) H, dated [DATE], showed: - He/she was taking trash out of the facility and saw Resident #65's call light was on; - Resident #65 said he/she turned the call light on because the resident in the next room was yelling for help; - When he/she knocked and opened the door, he/she found the resident on the floor and he/she called the charge nurse. Review of a nurse's note, dated [DATE] at 2:44 P.M., showed: - Resident was noted by nursing staff to be laying on floor in room in front of his/her bed. - When asked, the resident stated that he/she was up walking without assistance or using, he/she walked to find something to do and became dizzy and fell to the floor. - Resident assessed for any fracture to hips, arms or legs. - Verbally denies pain with movement. - Resident was noted to be wearing regular socks and not proper footwear. - Resident's daughter called and primary care physician faxed and all made aware of the fall. - Resident brought out to the nurse's station for observation. - Neuro checks re-instated. Review of the facility's incident investigation for the [DATE] - 2:44 P.M., showed staff documented the resident had another fall with no injury noted at time of incident. Review of the nurse's note, dated [DATE] at 3:09 P.M., showed: - Resident found on floor laying on right side. - Resident denies hitting head. - Resident assessed and helped into wheelchair. - Resident states he/she hurt everywhere and feels like he/she may have had a stroke over the weekend; - Resident's speech was slurred. - Notified doctor and family of fall. - New order given to send the resident to local emergency room . Review of the facility's incident investigation for the [DATE] - 3:09 P.M., showed staff documented the resident had another fall with no injury noted at time of incident. Review of the hospital's record, History of Present illness, dated [DATE] at 5:44 P.M., showed: - Patient presents via emergency medical service (EMS) complaining of forehead pain, left shoulder pain status [REDACTED]. - Patient states he/she loses his/her balance. Review of the hospital cat scan (CT, an X-ray image made using a form of tomography in which a computer controls the motion of the X-ray source and detectors, processes the data, and produces the image) report, dated [DATE] at 5:52 P.M., showed the resident suffered from an acute or subacute nondisplaced (did not displace bone) fracture through the [MEDICATION NAME] 6-7 bridging osteophyte (adjacent vertebrae are fused together, thereby forming a bone bridge across the intervertebral disc called a bridging osteophyte). During an interview on 3/13/20 at 10:2 A.M., Resident #65 said; - They heard the resident next door yelling out for help or quite a while; - He/she did not want to interfere with the other resident's business and felt surely the other resident had turned his/her call light on; - After quite a while had passed and he/she was still yelling, he/she decided to turn his/her call light as well; - It was a good 30 to 45 minutes before anyone showed up; - The staff said he/she was taking trash out and noticed the call light on, he/she had not heard the call light sounding; - He/she did not know if anybody had fixed the call light system so they could be heard, but if not, it was not because they had not reported it often enough. During an interview on 3/13/20 at 2:5 P.M., the Director of Nurses (DON) said: - The facility had not opened the 200 hall for residents to live there; - Last Monday or Tuesday, Resident #65 and spouse walked up to me by my office on the 200 hall; - Resident #65 said the previous administrator told them they had to move to the 200 hall; - Spoke with Resident #65's children and said the residents would not be forced to move to the 200 hall but if they found a room they wanted to move into we would help them move; - Resident #49 and his/her roommate did not get a long so we asked the roommate if he/she wanted to check out the rooms on the 200 hall, which he/she did and also moved to the 200 hall; - Resident #6 had made trips to the 200 hall and indicated a room he/she wanted to move into, so we moved him/her; - The administrator and I decided we would allow residents who were more alert and oriented and who got around pretty well to move to the 200 hall; - She did not look at the resident's diagnoses; - She did not have access to the resident's care plan so did not know the resident had a care plan for falls; - Call lights were checked out by either she or the administrator turning the call light on in the room and the other stood outside the door to see if the light came on; - They did not check where the audible call lights rang to; - No nursing staff were assigned to be on the 200 hall; - She had thought that the 300 hall staff could swing around into the 200 hall and check on the residents; - She did find out later that each hall's call lights only rang to that hall's nurses station. - Staff should have documented the hematoma to the resident's forehead as an injury on the incident investigation; - She was responsible to monitor that every thing was correctly filled out on the incident reports. After she looked at them, she locked them. She had not locked these incident reports; - She did not have interview the staff that found the resident; - When she interviewed Resident #65, she did not ask how long Resident #6 had yelled for help before he/she turned on the call light for Resident #6 and did not ask how long the resident's call light had been on before staff responded - Staff know they should check on the residents on the 200 hall every two hours; - She had not thought about moving the resident closer to a staffed nurses' station after the second fall because she did not know there had been an injury. - She could not verify anything had been put in place even yet for the residents of the 200 hall to use that would notify staff they needed help. During an interview on 3/13/20 at 3:37 P.M., the administrator said: - She did not know if the call lights on the 200 hall rang into the 100 and 300 hall nurses' stations that were staffed; - The DON assigned the residents on the 200 hall to the 300 hall nurses' station because the small part of the 300 hall is just around the corner from the 200 hall; - When we are here, we walk the 200 hall; - We have not put anything in place for the residents on the 200 hall to be able to alert nursing they need help. 2. The administrator said the facility was a smoke-free facility and had no smoking policy. Review of Resident #23's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/14/20, showed: - Able to make daily decisions; - Current tobacco use, yes or no, was left blank. Observation on 3/12/20 at 7:04 A.M., showed the resident sat in the dark by him/herself outside the 300 hall exit door, smoking a cigarette. Observation on 3/12/20 at 8:30 A.M., showed the resident sat outside the 300 hall exit door in the rain alone, smoking. No red metal butt cans and no smokers' genie were present. During an interview on 3/13/20 at 5:15 P.M., Resident #23 said: - He/she currently smoked out back, there off the 300 hall for right now; - He/she only went out and smoked a couple times a day, maybe 3 or 4 cigarettes; - He/she did not throw his/her cigarette butts on the ground like staff threw theirs on the ground; - He/she put his/her cigarette out on the concrete, then threw it in the trash can that sat just inside the door of the facility; - He/she kept his/her cigarettes and lighter in his/her jacket pocket; - There was four residents who smoked out back; - The Director of Nurses (DON) had told him/her the facility was fixing a place outside by the laundry he/she thought. It would be real nice with benches to sit on and have those cylinders for us to put the butts in. 3. Review of Resident #26's MDS, dated [DATE], showed: - Able to make daily decisions; - Current Tobacco use was marked No. During an interview on 3/13/20 at 5:15 P.M., the resident said: - He/she smokes out front of the building and puts his/her cigarettes out on the ground; - He/she heard there was a place in the back where people smoked, but he/she thought that was mostly staff who did not want anyone seeing them smoking; - He/she kept cigarettes and lighter in the bedside drawer aand had for the past six months and nobody had bothered them; - When people made a big deal about smoking, that is when if became a problem. 4. Review of Resident #50's MDS, dated [DATE], showed: - Independent decisions were consistent and reasonable; - Current tobacco use, Yes or No, was left blank. During an interview on 3/13/20 a 5:19 P.M., the resident said: - When he/she came back from the hospital a week or so ago, he/she decided to quit smoking; - He/she did not really call it smoking when he/she only smoked a couple times a day maybe a cigarette or two each time - He/she was an adult and did not need anyone else keeping his cigarettes or lighters, they were in a drawer in his/her room, locked up. 5. Review of Resident #62's MDS, dated [DATE], showed: - Moderately impaired decision making skills; - Current tobacco use coded No. During an interview the resident when said: - No, he/she never went out back to smoke with the other resident; - He/she only smoked when out with his/her sister when allowed to do so. 6. During an interview on 3/13/20 at 5:25 P.M., the DON said: - She had caught a couple of residents smoking out back and had told those resident this was a smoke-free facility, they should not be smoking out back; - She had not reported the residents smoking to anyone; - She had not documented any education she had given the residents. During the interview on 3/13/20 at 5:32 P.M., the Administrator said: - She was unaware residents a the facility smoked; - If

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) residents smoked, they should have a care plan related to smoking; - These four residents had each signed an admission agreement that they would not smoke while at the facility; - There was no smoking policy, no resident smoking assessments and no smoking care plans. MO 2
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assure staff provided complete perineal care and catheter (a sterile tube inserted into the urinary bladder to drain urine) care in a manner to prevent a urinary tract infection [MEDICAL CONDITION] or the possibility of a UTI. This affected three of 18 sampled residents (Resident #42, #51 and #73). The facility census was 81. Review of the facility's Urinary Catheter Care policy, revised September 2014, showed: - The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder; - Be sure the catheter tubing and drainage bag are kept off the floor; - Use a washcloth with warm water and soap to cleanse the perineal folds using circular [MEDICAL CONDITION] around the insertion site; With a clean washcloth cleanse the catheter tubing from the insertion site to approximately four inches outward. 1. Review of Resident #42's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/23/20, showed: - Unable to make daily decisions; - Requires extensive assistance of staff with dressing, transfers, toilet use and personal hygiene; - Indwelling catheter and frequently incontinent of fecal material. Review of the resident's care plan, edited 1/28/20, showed: - Do not allow tubing or any part of the drainage system to touch the floor. Review of the resident's nurse's notes, dated 3/7/20, showed staff administered [MEDICATION NAME] (antibiotic) IM (intramuscular) for UTI. During an interview on 3/10/20 at 11:27 A.M., Certified Medication Technician (CMT) B said he/she had not paid attention if the resident's bag touched the floor. Observation on 3/10/20 showed: - At 11:27 A.M., the resident lying in bed with the catheter drainage bag hanging on the bed frame. The catheter tubing and drainage bag sat on the floor, with urine visible from the hall. - At 11:55 A.M., staff brought the resident into the dining room in his/her wheelchair; the tubing dragged the floor. - At 3:03 P.M., the resident sat in his/her room in his/her wheelchair with the catheter drainage bag and tubing dragged the floor. Observation on 3/12/20 at 10:04 A.M., showed the resident sat in his/her wheelchair. The tubing and drainage bag lay on the floor. At 12:05 P.M., the resident sat in his/her wheelchair in the dining room with at least six inches of tubing lay on the ground. Observation on 3/13/20 at 1:54 P.M., showed while Licensed Practical Nurse (LPN) B pushed the resident in his/her wheelchair from the dining room down the hallway to his/her room the tubing and corner of drainage bag dragged the floor. Observation on 3/13/20 at 2:00 P.M., showed CNA E emptied urine from the resident's catheter bag. Between 6 to 8 inches of tubing lay on the floor. CNA E did not reposition the tubing up off the floor. During an interview on 3/13/20 at 2:07 P.M., CNA E said neither the drain bag nor tubing should touch the floor. During an interview on 3/13/20 at 2:09 P.M., LPN B said catheter drain bags and tubing should never touch the floor. Observation on 3/13/20 at 2:10 P.M., showed LPN B readjusted the residents drainage bag on the cross bar underneath the wheelchair. The resident was moving his/her feet and legs to move his/her wheelchair and by 2:12 P.M., the drainage bag slid down the cross bar until the drain bag rested on the floor. 2. Review of Resident #51's MDS, dated [DATE], showed: - Severely impaired decision making skills; - Dependent on staff for toilet use and personal hygiene; - Indwelling catheter. Review of the resident's care plan, initiated on 2/21/20, showed: - Cleanse catheter with soap and water, rinse and pat dry every shift and as needed if soiling occurs. Observation on 3/10/20 at 9:52 A.M., showed the resident lying in bed the catheter drainage bag hanging on the side of the bed. The resident's Broda chair (a tilt in space comfortable positioning chair) was rolled up next to the wheel until it touched the drainage bag. Observation on 3/12/20 at 10:39 A.M., showed the resident lying in bed. His/her catheter drainage bag hung on the side of the bed. The resident was incontinent of bowel with a large loose amount of fecal material. CNA B and CNA C provided perineal and catheter care for the resident. CNA B did the following: - Wiped one time down the right groin and one time down the left groin with separate wipes; - Without cleaning the center of the perineal area, he/she took a clean wipe and wiped one time down the catheter tubing from near the insertion site; - Staff ran the drainage bag down the resident's pants leg and laid the catheter drainage bag on top of a pillow that laid on the end of the bed and was above the resident's bladder. During an interview on 3/12/20 at 12:08 P.M., CNA B said: - If a resident had fecal material, he/she cleaned that before he/she cleaned the front side of the resident; - He/she should have cleaned the perineal area by the insertion site before he/she cleaned the catheter tubing; - He/she should have wiped the catheter tubing with an alcohol wipe not a pre-moistened wipe, but he/she did not have an alcohol wipe. 3. Review of Resident #73's annual MDS, dated [DATE], showed: - Required extensive assistance for transfers and dressing; - Had a urinary catheter. Review of the resident's nursing progress notes, dated [DATE], showed the resident received [MEDICATION NAME] 875 milligrams (mg) twice a day for ten days for a UTI. Review of the resident's care plan, revised on 3/2/20, showed: - Had a self-care deficit related to left-sided weakness after a stroke; - Required extensive assistance for transfers and dressing; - Had a suprapubic catheter (a tube surgically inserted into the bladder through the abdominal wall to drain urine); - Interventions did not address ensuring that the tubing did not touch the floor. Observation on 3/10/20 at 12:11 P.M., showed the resident self-propelled his/her wheelchair down the hall. His/her catheter tubing protruded from the bottom of his/her pant leg and the tubing dragged on the floor. 4. During an interview on 3/13/20 at 8:01 A.M., the Director of Nursing (DON) said: - Catheter bags and tubing should not be on/touch the floor. - If this should occur, staff should immediately notify the nurse to change them. - Staff should cleanse inside the skin folds around the catheter insertion site with catheter care. - Staff should clean fecal material until none shows on the wipes;
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, interview and record review, the facility failed to ensure the facility policy provided staff with clear directions for verifying the placement of a feeding tube (a tube that is placed directly into the stomach through an opening in the abdominal wall for administration of fluids, nutrition and medications) prior to medication administration for one out of 18 sampled residents (Resident #181), who was one of two residents identified as having feeding tubes. The facility census was 81. Review of the facility's policy for medication administration through a feeding tube, dated April 2018, showed: - The purpose of this procedure is to provide guidelines for the safe administration of medications through a feeding tube. - Confirm placement of the feeding tube (it did not provide further instructions as to how to confirm placement). - If you suspect improper tube position, do not administer feeding or medication and notify the charge nurse or physician. - Check gastric residual volume (GRV) to assess for tolerance of the feeding. - When correct tube placement and acceptable GRV have been verified, flush the tubing with 15-30 milliliters (ml) of warm sterile water (or prescribed amount). - Proceed with medication administration. 1. Review of Resident #181's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 3/10/20, showed: - Severely impaired cognitive skills for decision-making; - Non-verbal; - [DIAGNOSES REDACTED]. Review of the resident's active physician orders, as of 3/12/20, showed: - Diet: nothing by mouth; - [MEDICATION NAME] 1.5 (therapeutic nutrition that provides complete, balanced nutrition for long- or short-term tube feeding) at 50 ml/hour continuously per feeding tube with 100 ml water flush per tube every four hours; - [MEDICATION NAME] syrup, 10 ml via feeding tube four times a day for pain. Observation and interview on 3/12/20, at 9:28 A.M., showed Licensed Practical Nurse (LPN) A administered medications through the resident's feeding tube in the following manner, and said: - Checked the Medication Administration Record [REDACTED]. - That is the protocol staff should use to verify feeding tube placement. During an interview on 3/13/20, at 8:01 A.M., the Director of Nurses (DON) said staff should check for tube feeding placement with a free flush (by gravity) of 30 ml of water, then it is considered to be patent.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to assure staff provided proper respiratory care

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) when staff failed to properly to date tubing/humidifiers when opened and put in use which affected three of 18 sampled residents (Residents #20, #49 and #69). The facility census was 81. 1. Review of the facility's oxygen administration policy, revised October 2010, showed: - Verify that there is a physician's order for this procedure; - Review the physician's orders or facility protocol for oxygen administration; - Review the resident's care plan to assess for any special needs of the resident; - Periodically re-check the water level in the humidifier; - Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered. 2. Review of Resident #20's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/11/20, showed: - Able to make daily decisions. - Oxygen use was not coded. Review of the resident's care plan, edited 1/13/20, showed: - Administer oxygen per order; - Observe oxygen precautions per facility policy. Review of the resident's active March, 2020 physician order sheet (POS), showed the physician ordered: - Oxygen use. Delivery Device 2L/NC (liters per nasal cannula) continuous. Titrate up to 5L/NC to keep oxygen saturation level above 90 %related to acute and chronic [MEDICAL CONDITION]. - [MEDICAL CONDITION] at 16/10 ST (a [MEDICAL CONDITION] ST machine is a machine that initiates the breath, the higher pressure number is needed for inhalation and the lower number is needed for exhalation) with rate of 10 and oxygen 3L/minute nightly; - Change oxygen tubing/nebulizer tubing weekly on Sunday, night shift. Ensure tubing is labeled with the date and placed in a clean plastic bag. Observation and interview on 3/10/20 at 9:34 A.M., showed the resident sat in a wheelchair in his/her room with a nebulizer with undated tubing, an oxygen concentrator with tubing dated 2/1/20, a bottle of humidifier water attached to the concentrator dated 12/4/19, and a [MEDICAL CONDITION] machine. The resident tapped his/her [MEDICAL CONDITION] machine and said he/she used that every night with his/her oxygen. Observation on 3/13/20 at 8:26 A.M., showed no date on the tubing attached to the nebulizer and tubing dated 2/1/20 on the oxygen concentrator with a humidifier bottle dated 12/4/19. 3. Review of Resident #69's MDS, dated [DATE], showed: - Able to make decisions; - Oxygen use. Review of the resident's care plan, edited 2/9/20, showed: - Educated resident on importance of using oxygen; - Oxygen settings: 2L/NC, titrate to maintain oxygen saturation level at 88% or greater. Review of the resident's active March, 2020 POS, showed: - Oxygen Use: Delivery device 2L/NC as needed to keep oxygen saturation level greater that 90%. Monitor every shift and as needed. Observation on 3/10/20 at 2:45 P.M., and on 3/13/20 at 7:55 A.M., showed his/her nebulizer tubing and oxygen concentrator tubing had no date. 4. Review of Resident #49's MDS, dated [DATE], showed: - Able to make daily decisions; - Oxygen use. Review of the resident's active March, 2020 POS, showed: - Oxygen Use: Delivery device 3L/NC as needed to keep oxygen saturation level greater that 90%. Monitor oxygen every shift and as needed for shortness of air related to chronic [MEDICAL CONDITION] with [MEDICAL CONDITION] (low blood oxygen). - Change oxygen/nebulizer tubing weekly on Sunday night shift. Ensure tubing is labeled with the date and placed in a clean bag. Observation on 3/10/20 at 10:40 A.M., and on 3/13/20 at 8:01 A.M., showed the resident's oxygen concentrator tubing and portable oxygen tank tubing were not dated. 5. During an interview on 3/13/20 at 8:01 A.M., the Director of Nursing said staff should: - Change the oxygen tubing and humidifier water bottles every Sunday; - All tubing should be dated on the hub with tape, the humidifier bottles and the plastic bags should all be dated and changed every week.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to administer medications with an error rate of less than 5%. Staff made three errors out of 30 opportunities for errors, resulting in a medication error rate of 10%. This affected two out of 18 sampled residents (Resident #42 and #49). and one additionally sampled resident (Resident #78). The facility census was 81. Review of the facility's policy related to medication administration, dated December 2012, showed: - Medications shall be administered in a safe and timely manner, and as prescribed. - Medications must be administered in accordance with the orders. - The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 1. Review of the package insert for the [MEDICATION NAME] Diskus inhaler showed: - Used to treat asthma and [MEDICAL CONDITION] ([MEDICAL CONDITION]-a disease that causes narrowing of the lung passages and difficulty breathing); - Slide the Diskus lever away from you as far away as it will go until it clicks-a dose is ready to be inhaled. - Breathe out fully, put the mouthpiece to your lips and breathe in quickly and deeply through the Diskus. - Remove the Diskus from your mouth and hold your breath for about ten seconds, or as long as is comfortable, then breathe out slowly. - The Diskus delivers your dose of medication as a very fine powder which most patients can taste or feel. - Do not use another dose from the Diskus if you do not feel or taste the medication. Review of Resident #78's active physician's orders [REDACTED]. Observation on 3/11/20, at 9:33 A.M., showed Certified Medication Technician (CMT) A administered the resident's [MEDICATION NAME] Diskus in the following manner: - Obtained the [MEDICATION NAME] Diskus from the medication cart and checked the resident's name and dose; - Took the Diskus to the resident's room and handed it to the resident without providing any instruction; - The resident set the dose on the Diskus, deep breathed, exhaled, put the mouthpiece to his/her lips and inhaled quickly two times, then held his/her breath a few seconds after the second inhalation; - The CMT had the resident rinse his/her mouth with water and spit afterwards. During an interview on 3/11/20, at 9:36 A.M., CMT A said: - The directions instructed for the resident to inhale once, but he/she always inhaled twice. - The resident received instructions to inhale just once, but he still inhaled twice. - He/she had administered his/her own Diskus this way for so long that he/she just continued to do it this way. 2. Review of www.drugs.com for Breo Ellipta (inhaler) define showed: - Use breathing in only. Review of Resident #49's active March, 2020, POS and electronic medication administration record (E-MAR) for March 2020, showed the physician ordered: - Breo Ellipta Aerosol Powder Breath Activated 100-25 mcg/inhalation for [MEDICAL CONDITION]; - The E-MAR directed the resident to inhale once and only once. Observation on 3/12/20 at 9:28 A.M., showed CMT B did not give the resident any instruction when he/she handed the resident his/her Breo Ellipta inhaler. The resident placed the inhaler in his/her lips and immediately inhaled and exhaled three times. During an interview on 3/13/20 at 11:42 A.M., CMT B said; - The resident probably blew what he/she inhaled back out; - There were more residents who puffed their inhaler the same way, but he/she should have told him/her only take one inhalation. 3. Review of Resident #42's active March 2020, POS showed the physician ordered: - [MED] [MED] Solution 100 units/ml (millilter), inject 5 units before meals; - [MED] KwikPen Solution 100 units/ml, inject as per sliding scale (SS, units of [MED] based on the current finger stick): if the finger stick is 0 - 60 =0, call physician; 121 - 200 = 0; 201 - 250 =1; 251 - 300= 2; 301 - 350 = 3; 351 - 400 = 4; 401- call physician. Observation and interview on 3/11/20 at 7:43 A.M., showed Licensed Practical Nurse (LPN) B completed an accucheck (process to check blood sugar levels) on the resident, with a reading of 290. LPN B looked at the E-MAR and said it was difficult to read such small print, determined the resident needed 4 units of SS, retrieved the [MED] [MED] from the medication cart, applied a needle dialed up the 5 units of scheduled [MED] and dialed up four more units. LPN B administered 9 units of [MED] in the resident's abdomen. During an interview on 3/12/20 at 2:23 P.M., LPN B said: - He/she should have looked at the E-MAR correctly and know how much [MED] to give residents; - Staff fixed the print and made it easier for him/her to read now. 4. During an interview on 3/13/20 at 8:01 A.M., the Director of Nurses said: - She expected staff to follow the physician's orders [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff properly discarded expired medication. The facility census was 81. Review of the facility policy titled Storage of Medications, dated [DATE], included the following: - The facility shall store all drugs and biologicals in a safe, secure, and orderly manner; - The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; - The facility shall note use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. Review of the facility policy titled Discarding and Destroying Medications, dated [DATE], included the following: - Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances; -

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LIBERTY HEALTH & WELLNESS	2201 GLENN HENDREN DR LIBERTY, MO 64068

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) Non-controlled and Schedule V controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications; - Ointments, creams, and other like substances may be discarded into the trash receptacle in the medication room; - The policy did not specify the timeframe the non-controlled medications would be destroyed. 1. Observation of the medication storage room on [DATE] at 10:30 A.M., of the 100 hall showed: - 11 total [MEDICATION NAME] vials, expired February 2020; - Two bottles of glucose tablets expired [DATE], one bottle opened and one unopened; - One bottle of [MEDICATION NAME] Q-10 mg tablets unopened and expired February 2020; - Three pieces of hard salami laying loose in bottom shelf of fridge; - Frozen T.V. dinners without resident names stored in freezer. 2. Observation and interview on [DATE] at 10:50 A.M., showed a full box of approximately 100 medication cards on the counter of medication to go back to the pharmacy. The box included: - Resident #133 who discharged on [DATE] to a different facility which included: seven [MEDICATION NAME] 200 mg tablets; seve carvedilol 6.25 miligrams (mg); eight [MEDICATION NAME] 10 mg; 13 [MEDICATION NAME] 100 mg; five tamsulosin .4 mg; 15 [MEDICATION NAME] 500 mg tablets; eight bethaneechol 50 mg tablets; - Resident #132, who expired [DATE] which include: 29 metorprolo [MEDICATION NAME] 25 mg tablets; seven [MEDICATION NAME] 100 mg. - Certified Medication Technician (CMT) B said Resident #133 discharged to another facility and Resident #132 expired at the facility. 3. Observation of License Practical Nurse (LPN) B and the medication cart for the 100 and 200 hall showed: - [MEDICATION NAME] ointment expired [DATE]. 4. Observation of CMT C's medication cart showed: - [MEDICATION NAME] Silver dated opened [DATE] and expiration date of [DATE]; - Multivitamin expired February 2020. 5. During an interview with CMT B on [DATE] at 10:35 A.M., - Expired medication should be destroyed; - Discontinued medications and medications of residents who have discharged or expired are sent back to the pharmacy as often as needed, typically within 30 days.
F 0800 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to serve meals in a timely manner. This affected three of 18 sampled residents (Residents #25, #131, and #73) and did not serve all the residents at the same table at a time which affected one sampled resident (Resident #25). The facility census was 81. The facility did not provide a policy regarding meal service. 1. Review of Resident #25's comprehensive Minimum Data Set (MDS), a federally mandated assessment tool completed by facility staff included the following: - admitted [DATE]; - Cognitively intact. During an interview on 3/10/20 at 10:41 A.M. the resident said sometimes it takes an hour for him/her to get his/her food after going to the dining room. Observation on 3/10/20 at 11:47 A.M., showed the following: - Several residents, including Resident #25 waited in the dining room to be served; food had not begun being served yet; - The first tray was served from the kitchen at 11:58 A.M.; - A resident at Resident #25's table was served his/her meal at 12:15 A.M.; - Resident #25 received his/her meal at 12:22 P.M.; - Several other residents at other tables were served in between the times of the resident's tablemate and him/her being served. 2. Review of Resident #73's annual MDS, a federally mandated assessment instrument completed by facility staff, dated 2/12/20, showed he/she was cognitively intact. During an interview on 3/10/20, at 11:37 A.M., the resident said: - Meals are many times up to one to one and a half hours late. - Staff say lunch starts at 11:30 A.M., but we have to sit and wait and wait. 3. Review of Resident #20's MDS, dated [DATE], showed: - Able to make daily decisions. During an interview on 3/10/20 at 9:26 A.M., the resident asked, Can we just skip talking about the food? He/she said: - Sometimes it is okay, sometimes it just is not good; - The meat can be so tough residents cannot eat it; - The vegetables are overcooked and there is little to no seasoning; - It would be nice at times to have some fresh vegetables and fruit. 4. Review of Resident 49's MDS, dated [DATE], showed: - Able to make daily decisions. During an interview on 3/10/20 at 9:40 A.M., the resident said: - Most of the food here is not too bad; - Meat is tough more often than not; - Nobody ate the fish they had the night before; nobody could eat it; - It did not look good; it was not even warm; - He/she thought maybe the kitchen staff just thawed out the hush puppies, he/she did not believe they had been cooked. 5. During an interview on 3/13/20 at 8:50 A.M., the Dietary Manager (DM) said: - Breakfast started at 7:30 A.M., lunch at 11:30 A.M., and dinner at 5:30 P.M.; - Her opinion was residents should not wait more than 30 minutes for their meals, but a lot of residents like to drink coffee and visit; - She had heard complaints about long wait times; - She tried to make sure staff were ready on time but sometimes they have to wait for nursing to get to the dining room; nursing helped pass trays and drinks; - They would like to serve residents on a first come first serve basis but were not doing that currently. They try to serve one table at a times. Staff need to communicate with the kitchen when their tablemate is at the table; - Resident #25 should have been served around the same time as his/her tablemate.
F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure all residents were offered and/or had access to bedtime snacks. The facility census was 81. 1. During an interview with the resident group on 3/11/20, at 11:50 A.M., the group said: - Staff do not bring evening snacks around to each room and offer them and they do not bring them out until after 8:00 P.M. - Snacks are at the nurses' station and residents must go get them. - Six of the 24 residents present had a [DIAGNOSES REDACTED]. - The residents have told staff several times that they were not offered evening snacks and staff replied that they would try to do better. 2. Review of Resident #20's MDS, dated [DATE], showed: - Able to make daily decisions. During an interview on 3/10/20 at 9:26 A.M., the resident said: - Staff do not bring me a bedtime snack; - There is a cart of snacks kept at the nurses' station. 3. Review of Resident 49's MDS, dated [DATE], showed: - Able to make daily decisions. During an interview on 3/10/20 at 9:40 A.M., the resident said: - Staff did not bring him/her snacks before bedtime; - He/she had some snacks in his/her room, and they did have vending machines. 4. During an interview on 3/13/20, at 4:05 P.M., Certified Medication Technician (CMT) D said: - Staff offered evening snacks to residents, room-to-room, each evening. - He/she was a new staff, so he/she did not know if staff documented that staff offered them or how much each resident ate or drank. During an interview on 3/13/20, at 4:08 P.M., Licensed Practical Nurse (LPN) C said: - The kitchen staff brought out evening snacks. - A CNA was assigned to each hall to pass out snacks. - He/she thought they went to each room to offer them. - There was also a supply of snacks at the nurses' station if residents wanted to help themselves. - Nursing staff could also go to the kitchen to get snack items, if needed. During an interview on 3/13/20, at 4:12 P.M., Certified Nurse Aide (CNA) D said: - He/she had only worked there five days. - CNAs and CMTs go room-to-room and offer evening snacks. - He/she did not know if staff documented evening snacks. During an interview on 3/13/20, at 4:17 P.M., the dietary manager (DM) said: - Dietary staff brought trays of snacks to each unit after the evening meal, just before they left for the -around 8:00 P.M. - Nursing staff handed out the snacks. - There were usually only a few packages of cookies or crackers left on the trays when dietary staff picked them up the next morning. During an interview on 3/13/20, at 4:25 P.M., LPN D said: - Dietary staff brought out trays of snacks and set them at the nurses' station. - Staff did not offer them to residents room-to-room. - Residents had to get them themselves. - Any

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F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) resident who requested a snack would get one, but if they were not able to ask, they probably would not receive a snack. - Some residents took several snacks, so some may not receive any. - At one time, possibly about 4-8 months ago, staff offered evening snacks to residents by going room-to-room, but that only lasted about two weeks. - There is no place to document who staff offered a snack or how much they consumed. During an interview on 3/13/20, at 4:50 P.M., the Director of Nurses (DON) said: - She was not familiar with the facility's evening snack procedure yet. - She thought staff should offer each resident a snack since some residents might not be able to request or obtain one themselves. - She was not aware of any documentation for evening snacks.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review, and interviews, the facility failed to ensure staff washed their hands and disposed of papertowels appropriately, store cookware and dishes in a sanitary way, properly thaw meat, store food in a sanitary manner and failed to maintain the kitchen and food service and dish room in a sanitary manner, which affected all residents who received their food from the facility's kitchen. The facility census was 81. Review of the dietary contractor policy titled Cold Food Storage, dated November 2019, included the following: - It is thee company's policy to insure all frozen and refrigerated food items will be appropriately stored within guidelines of the United States Department of Agriculture Food Code; - The Food Service Director Is responsible for storing all products 6 inches above the floor and 18 inches away from any sprinkler unit; - The Food Service Director and/or Cook(s) will insure all food items not for immediate use, are stored properly including: o Labeled and dated: must have food common name, and have two date system (prepared date and use by date); - The food Service Director and/or Cook(s) thaw frozen items by: o Under refrigeration, this is recommended way of the company; o In a sealed container immersed in cold running water; o In a microwave for immediate use Review of the kitchen staff checklists included the following: - Check stock for dates, all food covered daily (Afternoon Cooks) - Sweep and Mop daily (Afternoon Cooks) - Sweep and mop dish room and ice machine room (Afternoon Aides) - Preparation tables and shelves daily (Morning Aides); - Stove, grill, burners, back splash: Tuesday, Thursday, and Saturday. 1. Observation on 3/10/20 beginning at 8:31 A.M. in the kitchen showed the following: - A large tube of thawed hamburger floating in a sink full of water, there was no water running over it and the hamburger was warm to the touch; - The vent over the table with recipe books were caked with dust; - A box of steakhouse chicken breast was sitting directly on the floor in the walk-in freezer. - A plastic tub of Spanish rice with no date or label; - A plastic tub of barbeque chicken with no date or label; - Multiple plastic containers with stored cooking utensils and steam table lids, multiple food particles were in the bottom of the containers. - There was a sheet on the floor next to the oven, and food particles all over floor in food preparation area; - Grease were runs on wall, side of oven und under oven - The floor in dishwashing room discolored black colored and could be removed with a damp paper towel; - Under and behind the ice machine, the floor had dirt and debris. 2. Observation on 3/12/20, starting at 10:31 A.M., showed: - A large buildup of a thick black substance on the floor tiles and in the grout; the dietary manager (DM) mopped the floor, leaving black balls of dirt which came up out of the grout with each pass of her mop; - Parts of the grout lines had light gray flecks covering the lines; the DM said she thought this was paint from the floor of walkin cooler, getting stuck to shoes; - The vent cover located in the ceiling outside the walkin freezer hung down - Cook A washed his/her hands, removed a marker from his/her pen and dropped it on the floor; he/she picked it up and sat it on the counter and kept working without washing his/her hands; - Dried particles of pureed food ran down the side of the RoboCoup (food processer); - Dietary Aide (DA) A brought a cart filled with dishes from the dishwashing area; all plates and bowls were stacked facing up; - After preparing pureed foods, Cook A washed his/her hands, pulled papertowels from the holder, dried his/her hands, and sat the wet papertowel on the steam table, then poured noodles in to cook; - Cook A then put raw, frozen chicken in a skillet to cook, washed his/her hands, pulled a paper towl to dry them and stuck the wet paper towel into his/her pants pocket. 3. During an interviews on 3/10/20 at 8:53 A.M. and 3/13/20 at 8:50 A.M. the Dietary Manager (DM) said: - The food had only been in the freezer for a couple days but it should be labeled and dated and discarded after three days; - The hamburger should not be thawed like that; meat should be thawed either by putting it in the refrigerator or put under cold, running water; - Floors get mopped twice a day and deck scrubbed a couple times a week, has gotten some of the black build up out of the grout but its better than it was when she started; - The grey flex was from the walk in refrigerator; - The back door closes if you slam it hard; - The vent hood was cleaned maybe a month ago if that but she was not sure if they did anything with the spray nozzles; - They had not done the deep cleaning she has wanted to do and planned to have it done in the next couple of weeks; - She had people hired and gotten them trained so she can focus on what she needs to do; - She needed to figure out clean dish storage; - Dishes should be stored upside down or covered with a bag. - The cook should not put paper towels on steam table or in his/her pocket, he/she should have been put in the trash.
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Dispose of garbage and refuse properly.** Based on observation and interview, the facility failed to ensure they disposed of garbage properly when staff did not keep the lids on dumpster located outside the kitchen entrance closed which allowed trash to not be properly covered and had the potential to attract roddents and insects. The facility census was 81. 1. Observation on 3/12/20 at 10:10 A.M., showed a large dumpster located on the south side of the building, off the kitchen exit. One lid of the two sided dumpster was open with white trashbags coming up out of the top of the dumpster. Observation on 3/12/20 at 5:30 P.M., showed the dumpster lid remained open and the white trash bags showing out the top of the dumpster. Observation on 3/13/20 at 8:10 A.M., showed both dumpster lids open and white trashbags coming out the top as well as laying on the ground around the dumpster. During an interview on 3/13/20 at 4:30 P.M., the Regional Maintenance Director said staff should not leave the lids of the dumpster open. This one was particularly tall so staff may have issues closing the lid after they deposited their trash bags.
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 record review and interviews, the facility failed to review and update their facility-wide assessment to determine what resources are necessary to care for their residents competently during both day to day operations and emergencies. The facility's census was 81. Review of the facility assessment, provided by the facility showed the assessment was last updated on 12/17/17 and again on 4/30/18. The information provided did not include any updates or evidence of review for 2019 or the first three months of 2020. During an interview on 3/12/20 at 12:30 P.M., the administrator said she had not been at the facility long as the administrator. She did not see any other assessments completed for 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 observations, interviews, and record review, the facility failed to ensure staff provided care in a manner to prevent infection or the possibility of infection when they did not change gloves or wash their hands between dirty and clean tasks, which affected three of 18 sampled residents, (Resident #24, #51 and #69). The facility census was 81. 1. Review of the facility's Handwashing/Hand Hygiene policy, revised August 2015, showed all personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of heath care-associated infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Wash hands with soap and water or alcohol based hand rub when: - Hands are visibly soiled; - After contact with a resident with infectious diarrhea; - Before and after direct contact with a resident; - Before performing any non-surgical invasive procedure; - Before and after finding any invasive device; - Before moving from a contaminated body site to a clean body site during care; - After contact with blood or bodily fluids; - After removing gloves. 2. Review of Resident #69's MDS, dated [DATE], showed: - Moderately impaired decision making skills; - Resident had no toilet use and only received personal hygiene once or twice; - Always incontinent of urine and fecal material. Review of

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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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) the resident's care plan, edited 2/9/20, showed: - Clean perineal area with each incontinent episode. Observation on 3/12/20 at 10:01 A.M., showed Certified Nurse Aide (CNA) B and CNA C entered the resident's room to provide care. CNA B washed his/her hands for less than five seconds. CNA C washed his/her hands and gloved then used a gait belt and transferred the resident to bed. CNA C provided perineal care to the resident and without washing his/her hands, placed a clean brief under the resident and assisted CNA B to pull the resident's pants up. CNA C then handled the remote control and positioned the bed into a low position and put the resident's call light with in reach before he/she washed his/her hands. During an interview on 3/12/20 CNA C said: - He/she should wash his/her hands before starting care and after finished providing care; - He/she should wash his/her hands when entering and before leaving a resident room; - He/she should wash his/her hands with every glove change. 3. Review of Resident #51's MDS, dated [DATE], showed: - Severely impaired decision making skills; - Dependent staff for toilet use and personal hygiene; - Indwelling catheter and occasionally incontinent of fecal matter. Review of the resident's care plan, initiated on 2/21/20, showed: - Cleanse catheter with soap and water, rinse and pat dry every shift and as needed if soiling occurs. Observation on 3/12/20 at 10:39 A.M., showed CNA B and CNA C provided perineal care for the resident in the following way: - CNA B wiped the resident's buttocks and removed large amounts of fecal material; - Without changing gloves or washing his/her hands, CNA B assisted the resident to roll to his /her back; - Without changing gloves or washing his/her hands, CNA B wiped once down the right groin and once down the left groin; - With the same gloves on, CNA B took a wipe and wiped down the catheter tubing from the insertion site downward away from the body. During an interview on 3/13/20 at 1:41 P.M., CNA B said: - He/she should wash his/her hands when first going into a resident's room; - He/she should wash his/her hands after he/she provided perineal care and before he/she left the resident's room. 4. Review of Resident #24's quarterly MDS, dated [DATE], showed: - Required extensive assistance for toilet use; - Had a urinary catheter. Review of the resident's care plan related to his/her catheter, dated 1/22/20, showed: - Required a catheter due to a [MEDICAL CONDITION] bladder (bladder dysfunction due to nerve damage); - Resident will have his/her catheter managed appropriately as evidenced by not exhibiting signs and symptoms of infection or trauma. Observation on 3/12/20, at 8:16 A.M., showed CNA A and CNA G provided care for the resident in the following manner: - Both staff washed their hands and put on gloves. - CNA A cleansed the resident's front genital area with moistened wipes; fecal material remained on the last moistened wipe. - CNA A then removed his/her gloves, washed his/her hands and put on new gloves. - CNA G cleansed the resident's backside and rolled the soiled bed pad toward the center of the bed, then removed his/her gloves, washed his/her hands and put on new gloves. - CNA A placed a new bed pad beneath the resident and applied barrier cream to the resident's buttocks, then removed his/her gloves, washed his/her hands and put on new gloves. - Staff turned the resident on his/her back and CNA A cleansed the resident's front genital area again, until no further fecal material remained, then, with the same soiled gloves on, CNA A grasped the resident's catheter tubing near the insertion site and wiped the tubing from the insertion site outward. - Both staff then removed their gloves and washed their hands. During an interview on 3/12/20, at 11:35 A.M., CNA A said staff should remove their gloves, wash their hands and put on new gloves between cleansing the genital areas and cleaning the catheter tubing. 5. During an interview on 3/13/20, at 8:01 A.M., the Director of Nurses (DON) said: - Staff should remove their gloves, wash their hands, then put on new gloves after they cleanse the genital areas, before they cleanse the catheter tubing. - She expected staff to wash their hands when they entered a resident room; - Staff should wash their hands after cleaning fecal matter; - Staff should wash their hands with each glove change and between clean and dirty tasks.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation and interview, the facility failed to provide a safe, sanitary comfortable environment for residents, staff and the public when the resident bathroom exhaust vents were coated in dust, and failed to maintain the facility's driveway. The facility census was 81. Review of the facility policy titled Departmental (Maintenance)- Plumbing, HVAC and Related Systems, dated June 2011, included the following: - The purpose of this procedure is to guide the sanitary handling of the plumbing, heating, ventilation, air conditioning, and related systems within the facility; - Clean air vents and air handling units at least annually. Maintain exhaust fans at least every six months. Review of the facility policy titled Work Orders, Maintenance, dated April 2010, included the following: - Maintenance work orders shall be completed in order to establish a priority of maintenance service; - In order to establish a priority of maintenance service, work orders must be filled out and forwarded to the Maintenance Director; - It shall be the responsibility of the department directors to fill out and forward such work orders to the Maintenance Director; - A supply of work orders is maintained at each nurses' station; - Work order requests should be placed in the appropriate file basket at the nurses' station. Work orders are picked up daily; - Emergency requests will be priority in making necessary repairs. 1. Observation on 3/13/20 beginning at 11:18 A.M. showed the following resident bathrooms' exhaust vents were covered in dust, dirt, and debris: - Rooms #310, #302, #307, #306. During an interview on 3/13/20 at 3:00 Housekeeper A and the Regional Housekeeping Representative said: - Housekeeping was responsible for cleaning exhaust vents in resident rooms; - Staff should dust the vents daily; - The vents on the 300 hall were dusted but they couldn't get the dust off; - They did not know if a maintenance work order had been submitted to clean the vents. 2. Observation on 3/13/20 at 7:20 A.M. of driving around the facility showed multiple large potholes in the driveway on the West and South side of the facility. Both portions of the driveway were designated as emergency evacuation routes. 3. During an interview on 3/13/20 at 5:20 P.M. the Regional Maintenance Director said: - Housekeeping should dust the exhaust vents in resident bathrooms; - He was not aware of any maintenance request to clean them due to staff being unable to dust them; - Maintenance logs were kept at the nurse station for requests, and were dated when the request was completed; - The facility had a part time maintenance worker and had just recently hired a maintenance director but he/she had not started yet - The potholes could make it hard for staff and residents to evacuate during an emergency.
F 0922 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have enough backup water supply for essential areas of the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interviews, the facility failed to ensure they had procedures in place to ensure they had enough water available in the event of the loss of the normal water supply. The facility had a census of 81. Review of the facility's entrance conference information showed as of [DATE], they had an emergency supply of water in the basement. They indicated they currently had 60 gallons of water in the facility. Observation and interview on [DATE] at 4:15 P.M., showed four packages which contained six gallons of water with one missing a gallon and six 5 gallon containers. The REgional Mainenance Director said they did not have enouough if they should have three gallons per day per resident with a census of 81. All of the gallons of water currently on hand had expired.
F 0923 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have enough outside ventilation via a window or mechanical ventilation, or both.** Base on observation and interview, the facility failed to maintain the exhaust system to remove bathroom odors. The facility census was 81. Review of the facility policy titled Departmental (Maintenance)- Plumbing, HVAC and Related Systems, dated June 2011, included the following: - The purpose of this procedure is to guide the sanitary handling of the plumbing, heating, ventilation, air conditioning, and related systems within the facility; - Clean air vents and air handling units at least annually. Maintain exhaust fans at least every six months. FACILITY Environment 03/12/20 10:10AM arrived at facility and drove around the building. In the rear of the building was a large trash dumpster. The trash was overflowing and the lid was open. 1. Observation on 3/13/20 beginning at 3:48 P.M. showed the following exhaust vents were not working: - Rooms #319, #314, and the exhaust vent in the server room in the 300 hall. During an interview on 3/13/20 at the same time the Regional Maintenance Director said someone may have worked on the motors to the exhaust vents on the roof.