STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265719	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKWOOD ESTATES NURSING & REHAB	5303 BERMUDA DRIVE NORMANDY, MO 63121

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure Resident #50, the roommate of a resident with a behavior of yelling out loudly, repetitively, and at all hours, was interviewed regarding how the roommates yelling affected him/her, and if the resident would prefer to move to another room. In addition, one non-nursing staff member failed to address Resident #33's request for assistance. The census was 97. 1. Review of Resident #50's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/23/19, showed: -[DIAGNOSES REDACTED]. Trouble failing asleep; -No behaviors; -Limited staff assistance for bed mobility; -Extensive staff assistance for dressing; -Total staff assistance for transfers, toileting, personal hygiene and bathing. Observation on [DATE] at 7:20 A.M., showed three nursing staff, including Nurse A, stood or sat at the 100/200/300 nurse's station. A loud voice saying something repetitively could be heard coming from the 300 hall. The surveyor asked who was making that noise. Nurse A said that's Resident #14. He/she is saying, mom. He/she does that all the time; Observation on 3/3/20 at 2:36 P.M., showed the resident sat outside his/her room holding his/her head with his/her hand. The resident's roommate was yelling mom,mom in a loud repetitive voice. When asked whether his/her roommate's repetitive yelling bothered him/her. The resident smiled and said, that noise is about to drive me crazy. He/she had not spoken to anyone about it but everyone knows about it. He/she has prayed to endure the noise and feels at times you have to endure some things. He/she is a believer in prayer and believes you have to endure sometimes. He/she believes the roommate knows what he/she is doing and he/she just tries to ignore him/her. He/she would greatly appreciate it if something could be done about it. He/she has prayed and prayed about it. He/she would not mind being moved to another room. Resident #14 doesn't make the noise all night, but it begins as soon as the resident wakes up. The resident said it would be alright if social services was made aware of his/her concerns and said thank you. He/she has prayed for someone to come and help him/her. During an interview on 3/3/20 at 2:45 P.M., the Social Service Director said he was unaware the resident wanted to move from the room because of the noise his/her roommate made. After speaking with the resident, he/she said he/she would be glad to speak to him/her about possibly moving to another room. Review of the resident's Social Services Note, dated [DATE] at 3:02 P.M., showed: -Social services was made aware that the resident had asked about switching rooms due to his/her roommate yelling out frequently; -He brought the resident to his office to speak to him/her further about her wanting to change rooms; -He asked the resident if he/she wanted to change rooms and the resident said yes; -He then asked the resident why he/she hadn't said anything about it before and the resident said he/she doesn't like to complain and that he/she was raised to not complain about anything; -He explained to the resident that if he/she has any issues the facility needed to know about them so they can address those issues and fix them for him/her; -He showed the resident another room and introduced him/her to his/her potential new roommate. The resident liked not only the room but also the roommate; -He then called the resident's family member to inform him/her of what was going on; -The family was also okay with moving the resident into the new room; -Housekeeping moved all of the resident's belongings into the new room; -He also informed the Director of Nursing (DON) and charge nurses of the resident's move; -The resident had no other concerns or needs, and was happy with the outcome; -Social services will continue to follow and monitor him/her for any new concerns or needs that he/she might have. During an interview on 3/5/20 at 6:00 A.M., Certified Nurse Aide (CNA) H said the resident's roommate hollers all the time. The resident never complained to him/her about the noise. During an interview on 3/4/20 at 9:21 A.M., Certified Medication Technician (CMT) I said the resident's roommate hollers all the time. The resident never complained to him/her about it. He/she would think the yelling out would cause the resident to be aggravated. During an interview on 3/5/20 at 2:05 P.M., the DON said she had not asked the resident whether the noise his/her roommate makes bothered him/her. No one has reported the resident had concerns regarding his/her roommate. 2. Review of Resident #33's admission MDS, dated [DATE], showed: -Adequate hearing and vision; -Clear speech - distinct intelligible words; -Makes self understood; -Understands others; -Independent for walking in room and corridor; -[DIAGNOSES REDACTED]. Observation on 3/3/20 at 6:48 A.M., showed the resident stood inside his/her room near the door entrance. An unknown maintenance employee walked by the room. The resident asked the maintenance worker an unknown question, to which the maintenance employee responded by saying he/she was in maintenance department, and the resident would have to tell someone that works in nursing. The maintenance employee then proceeded to walk on without informing anyone in the nursing department what the resident wanted. During an interview on 3/3/20 at 10:05 A.M., the resident sat on his/her bed. The resident had two pillows with no pillow cases on his/her bed. When asked the what he/she had asked the maintenance employee earlier that morning, the resident pointed at his/her bedside table where two pillow cases and one sheet sat. The resident said he/she had asked the maintenance employee if someone could make his/her bed, that's all he/she wanted. No one had come in to make his/her bed. During an interview on 3/5/20 at 2:09 P.M., the DON said she would have expected the maintenance employee to have helped the resident make his/her bed or to tell someone in nursing so the bed could have been made. It is everyone's responsibility, regardless of the department, to answer call lights or try to meet a resident's need. If the staff member cannot take care of the resident's request, then they should inform someone that can.
F 0569 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete and send a Third Party Liability (TPL) form (a form which is sent to MO Healthnet which gives an accounting of the remaining balance of that resident's funds in the resident trust account), which is required to be sent within 30 days after the death, for five of five residents reviewed who expired (Residents #300, #301 #302, #303 and #304). The census was 97. 1. Review of Resident #300's resident trust account, showed: -He/she expired on [DATE]; -On [DATE], his/her account showed $593.31; -On [DATE], the business office manager (BOM) completed a personal funds balance report to the TPL unit for $593.31. 2. Review of Resident #301's resident trust account, showed: -He/she expired on [DATE]; -On [DATE], the facility wrote a check to the funeral home for $100.00; -The facility failed to complete a TPL within 30 days of when the resident expired. 3. Review of Resident #302's resident trust account, showed: -He/she expired on [DATE]; -On ,[DATE], his/her account showed $149.00; -Facility staff failed to complete a TPL for the final accounting within 30 days of when he/she expired. 4. Review of Resident #303's resident trust account, showed: -He/she expired on [DATE]; -On [DATE], his/her account showed $100.00; -Facility staff failed to complete

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0569 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) a TPL for the final accounting within 30 days of when he/she expired. 5. Review of Resident #304's resident trust account, showed: -He/she expired on [DATE]; -The facility wrote a check to the funeral home for $1632.12, for funeral expenses; -Facility staff failed to complete a TPL for the final accounting within 30 days of when he/she expired. 6. During an interview on [DATE] at 11:49 A.M., the BOM said he/she took over in [DATE]. She knew that TPLs were supposed to be completed and also knew that they should be completed for funerals expenses as well.
F 0570 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assure the security of all personal funds of residents deposited with the facility.** Based on interview and record review, the facility failed to ensure they maintained a surety bond in an amount of one and one-half times the average monthly balance for the previous 12 months. The census was 97. Review of the facility's bond amount, approved by the Department of Health and Social Services, showed and amount of $60,000. Review of the resident trust account reconciliation statements for the months of January through December 2019, showed an average monthly balance of $54,000. Review of the required bond amount (1 1/2 times the average monthly balance), showed the facility was required to have a bond in the amount of $81,000. During an interview on 3/3/20 at 11:49 A.M., the business office manager said he/she took over in December 2019. The management team reviews the surety bond to make sure it is sufficient. The management team was hired in January 2020, to oversee the resident funds, accounts payable and all financial aspects. She was not aware they needed a higher amount for the bond. -
F 0604 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assist one resident observed with his/her left shoulder and arm wedged in the side rail on his/her bed for approximately 10 minutes. The resident was visible from the hallway as multiple staff passed his/her room. In addition the facility failed to assess the side rail usage for the resident's safety and ensure the use of the side rail was the appropriate and least restrictive device. The facility identified seven residents with side rails, five were sampled and problems were found with one (Resident #14). The census was 97. Review of the facility's Restraints-Side Rails policy, revised 6/2019, showed: Purpose: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms; -Definition: Physical restraints are defined by the Centers for Medicare and Medicaid Services (C[CONDITION]) as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restrict freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.); -General Guidelines: 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed.) (Note: The side rails may have the effect of restraining one individual and not the other, depending on the individual resident's condition and circumstances.) 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident's care plan. 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. 6. Less restrictive interventions that will be incorporated in care planning include: a. Providing restorative care to enhance abilities to stand safely and to walk; b. Providing a trapeze to increase bed mobility; c. Equipping the resident with a device that monitors attempts to arise; e. Providing staff monitoring at night with periodic assisted toileting for residents who can comprehend this information. 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rails will be obtained from the resident or legal representative, after presenting potential benefits and risks. (Note: Federal regulations do not require written consent for using restraints. Signed consent forms do not relieve the facility from meeting the requirements for restraint use, including proper assessment and care planing. While the resident or family (representative) may request a restraint, the facility is responsible for evaluating the appropriateness of that request.) 10. Manufacturer instructions for the operation of side rails will be adhered to. 11. The resident will be checked periodically for safety relative to side rail use. 12. If the side rail use is associated with symptoms of distress, such as screaming or agitation, the resident's needs and use of side rails will be reassessed. 13. When side rail usage is appropriate, the facility will access the space between the mattress and side rail to reduce the risk of entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used). 14. Side rails with padding may be used to prevent resident injury in situations of uncontrollable movement disorders, but are still restraints if they meet the definition of a restraint. 15. Facility staff, in conjunction with the Attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/2[DATE]9, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated 11/2[DATE]9, showed: -Problem: Risk for falls related to (r/t) daily use of [MEDICAL CONDITION] drug use, increased anxiety and restlessness. Resident has had a fall from bed, no injury r/t frequent movement; -Approach: Check range of motion (Specify #) times daily. For no apparent acute injury, determine and address causative factors of the fall. Monitor/document /report as needed (PRN) x 72 hours to physician for signs and symptoms of pain, bruises and changes in mental status. New onset: confusion, sleepiness, inability to maintain posture, agitation. -Place side rails up X 2 for safety. Review of the resident's physician's orders [REDACTED]. Review of the resident's medical record, showed no side rail assessment was completed. Observation on [DATE], showed: -7:16 A.M., during the initial tour of the facility, the resident was calling out loudly mom, mom from the centralized nurse's station. The resident's room was the first room on the right, visible from the nurse's desk. The resident called out repeatedly mom, mom. His/her voice was high pitched, loud and urgent. The resident was partially behind the privacy curtain but visible from the hallway. The resident lay in his/her bed, on a bare mattress, with the head of the bed slightly raised, moving his/her legs back and forth. Both half side rails were up. His/her head was raised at an awkward angle, with his/her left shoulder and arm wedged between the mattress and half side rail on the left side. The resident moved his/her legs and feet in a sliding motion on the mattress. The lower half of the bed was raised slightly at the knees. He/she repeatedly called out mom, mom in a urgent loud voice. Three unidentified nurses were at the nurse's desk. No one from the nurse's desk checked on the resident; -7:20 A.M., three nursing staff, including Nurse E, stood or sat at the 100/200/300 nurse's station. A loud voice saying something repetitively could be heard coming from the 300 hall. When asked who was making that noise. Nurse A said it was Resident #14. He/she is saying mom. He/she does that all the time; -7:21 A.M.: two unidentified certified nurse aides (CNAs) passed the resident's room. Neither staff member looked in the room. The resident continued to call out repeatedly mom, mom in a loud high pitched voice. The resident remained with his/her left arm/shoulder wedged between the mattress and left side rail; -7:23 A.M.: one unidentified CNA passed the room, looked in the room, twice, but did not go in. The resident continued to yell out mom, mom in a loud high pitched voice; -7:26 A.M.: a nurse passed the resident's room on his/her way to the nurse's station, walked back, looked in the room, went in and straightened the resident onto the center of the mattress. He/she lay on a bare mattress, without a sheet, moving his/her legs up and down. The side rails were raised on both sides. He/she continued to call out mom, mom but it was no longer high pitched; -8:30 A.M.: the resident was slumped over to the left of the bed, leaning against the side rail. During an interview on 3/5/20 at 6:00 A.M., CNA H, said he/she has taken care of the resident on the day shift. He/she has often found the resident against and or wedged between the mattress and the side rail. The resident moves in his/her bed and has to be positioned frequently when in bed. He/she had not reported it to anyone and said everyone is aware the resident does this. During an interview on 3/15/20 at 4:34 P.M., CNA P said he/she has assisted other staff to take care of the resident on the day shift. He/she has helped position the resident in bed and helped with transfers. He/she has had to hold the resident's hands while staff provided care. He/she

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F 0604 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) hasn't seen the resident in the side rail. During an interview on 3/15/20 at 4:45 P.M., CNA Q said he/she has taken care of the resident on the night shift. The resident usually sleeps during the night. The resident does slide down in the bed because of the type of mattress he/she has. It takes two staff to position him/her in the bed. The resident is active and moves his/her legs in bed when awake. During an interview on 3/4/20 at 7:08 A.M., Nurse B said he/she works the night shift. When the resident is awake he/she hollers out. He/she heard the resident holler the morning of [DATE]. The resident's holler sounded different, more urgent. As he/she entered the room, he/she could see the resident's left shoulder and arm was wedged in the side rail. He/she repositioned the resident at that time. He/she was unaware staff had passed the room. He/she would expect the staff to go in and check on the resident. He/she did not report the resident was wedged in the side rail to anyone. During an interview on 3/4/20 at 10:28 A.M., the Maintenance Director said no one reported the resident was sliding down between the mattress and side rail. He checked the half side rail at this time and was able to lock it in place so it stopped it from moving. He was unaware how long the side rail had been loose. He would have expected the staff to report anytime they find problems with side rails. In addition he was aware he should measure the gap between the mattress and side rail to make sure a resident wasn't able to slide between them. He has not begun measuring any of the side rails. During an interview on 3/13/20 at 10:43 A.M., the Director of Nurses (DON) said she has worked at the facility since July of 2019 and the resident has used the side rails since then. Staff did not report any problems with the resident's side rails. She would have expected the staff to report any problems to the charge nurse or DON. They were doing side rail assessments but when the facility changed the electronic charting from one company to another in September of 2019, and the side rail assessments weren't being completed due to a problem with the system. She was unaware they still weren't being completed until now. She is aware the facility should assess side rails for safety which includes measuring the gaps between the mattress and the side rail and ensure the side rails are in good repair. The prior Maintenance Director was assessing the side rails for safety. He took the documentation regarding the assessments with him. During an interview on 3/5/20 at 7:44 A.M., the administrator said the Maintenance Director reported the resident's loose side rail. The side rail was removed and his/her mattress was replaced with a Bolster mattress (mattress with built in raised sides). This was the first time she was made aware of the problem with the side rail. She was unaware the resident was wedged in the side rail. In addition she was not aware staff failed to assist the resident while he/she was wedged in the side rail even though he/she was visible as they passed the room. She would expect staff to immediately go in reposition the resident, assess him/her for pain and injury and report it to the charge nurse and DON. Staff should not pass the room without assessing the resident. During an interview on [DATE] at 2:26 P.M., the DON said she expects the staff to follow the policy. During an interview on 3/5/20 at 9:55 A.M., the resident's physician and facility Medical Director said he spoke with the facility regarding the resident. The resident has a behavior of yelling out but he would expect staff to assist the resident if he/she needed positioning. He also would expect the facility to follow the policies for Bed Safety and Proper Use of Side Rails. He was unaware the facility was not completing side rail assessments and doesn't recall the facility discussing it in the Quality Assurance meeting. He would also expect the facility to inspect side rails per the facility's policy.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete annual comprehensive assessments, using the resident assessment instrument (RAI) specified by the Centers for Medicare and Medicaid Service (C[CONDITION]) within 14 calendar days after admission and not less than once every 12 months, for three of 20 sampled residents (Residents #78, #83, and #80). The census was 97. 1. Review of Resident #78's medical record, showed: -admitted on [DATE]; -Admission assessment completed 6/15/17; -No annual comprehensive assessment completed in 2019 or 2020. 2. Review of Resident #83's medical record, showed: -admitted on [DATE]; -Admission assessment completed 7/30/18; -No annual comprehensive assessment completed in 2019 or 2020. 3. Review of Resident #80's medical record, showed: -admitted on [DATE]; -Annual comprehensive assessment completed on 9/13/18; -No annual comprehensive assessment completed in 2019 or 2020. 4. During an interview on 3/5/20 at 8:15 A.M., the MDS (Minimum Data Set, a federally mandated assessment instrument completed by facility staff), Coordinator said comprehensive resident assessments should be completed within 14 days of admission, and not less than 12 months since admission. 5. During an interview on 3/5/20 at 2:01 P.M., the Director of Nurses (DON) said the MDS Coordinator should complete resident assessments at the intervals specified by C[CONDITION].
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, accurately reflected the resident's status at the time of assessment for two of 20 sampled residents (Residents #88 and #35). The census was 97. 1. Review of Resident #88's quarterly MDS, dated [DATE], showed: -readmitted to facility on 11/15/19; -[DIAGNOSES REDACTED]. Observation on 3/3/19 at 6:56 A.M., showed the resident wore a smoking apron and stood by a door, leading to the facility's courtyard. The resident said he/she was waiting on a smoke break. Review of the facility's list of smokers, provided by the facility on [DATE], showed the resident was listed as a smoker. Review of the facility's incident/accident report, dated 12/1/19 through [DATE], showed on the resident was involved in an incident of physical aggression on 1/29/20. Review of the resident's progress notes, showed: -On 1/29/20 at 4:58 A.M., staff documented the resident was observed walking around the halls and yelling for someone. Staff attempted to redirect the resident, but he/she refused to return to his/her room; -On 1/29/20 at 10:34 A.M., staff documented the resident struck an employee in the face, twice, with a broken chair. Review of the resident's monthly weights, showed: -August 2019: 186.4 pounds (lbs); -September: Not documented; -October: 170.4 lbs; -November: 165.2 lbs; -December: 164 lbs; -January 2020: 162.4 lbs. Further review of the resident's weights, showed a severe weight loss (unplanned loss of 10% or greater in six months) of 12.88% between August 2019 and January 2020. During an interview on 3/5/20 at 8:15 A.M., the MDS Coordinator said the resident does not have a history of wandering or physical aggression. If the resident exhibited these behaviors, it should be indicated on the MDS. His/her weight loss should also be documented on the MDS. During an interview on 3/5/20 at 2:01 P.M., the Director of Nurses (DON) said all staff is aware of the resident's behavior issues, including physical aggression. These behaviors are discussed in the facility's weekly interdisciplinary team meetings, which are attended by the MDS Coordinator. The resident's behaviors should have been documented on his/her MDS. 2. Review of Resident #35's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's progress notes, showed: -On 12/[DATE]9, staff documented the resident refused a shower three times; -On 12/21/19, staff documented the resident's family informed of the resident's refusal to shower on that day and on 12/17/19. 3. During an interview on 3/5/20 at 2:01 P.M., the DON said all resident assessments should be completed accurately to reflect the resident's status at the time of assessment.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement comprehensive person-centered care plans with individualized interventions for one resident noted with severe weight loss (unplanned loss of greater than 5% in one month, greater than 7.5% in three months, or greater than 10% in six months), one resident with wandering behavior, and one resident with a history of rejecting care (Residents #88, #21, and #35). The census was 92. 1. Review of Resident #88's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/4/20, showed: -Severe cognitive impairment; -[DIAGNOSES REDACTED]. Review of the resident's monthly weights, showed: -August 2019: 186.4 pounds (lbs); -September: Not documented; -October: 170.4 lbs; -November: 165.2 lbs; -December: 164 lbs; -January 2020: 162.4 lbs. Further review of the resident's weights, showed a severe weight loss (unplanned loss of 10% or greater in six months) of 12.88% between August 2019 and January 2020. Review of the resident's nutrition notes, showed on 10/21/19, the registered dietician (RD) documented the resident noted with significant weight loss. Resident desired weight loss and refused health shakes. Staff reported the resident eats junk food from the vending machine. Staff

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) encouraged him/her to eat meals, not from the vending machine, but he/she still does it. During an interview on 3/5/20 at 5:45 A.M., certified medication technician (CMT) I said the resident has mental health [DIAGNOSES REDACTED]. He/she has lost a lot of weight. He/she does not eat much during meals, but likes other foods, such as burgers and fries. The resident snacks on food several times during a shift, instead of eating one meal. He/she is on a diabetic diet, but eats food from the vending machine. Review of the resident's care plan, undated and in use at the time of survey, showed: -Problem: Impaired nutritional status. Unplanned/unexpected weight loss related to poor food intake. Has [DIAGNOSES REDACTED]. Has had a medication adjustment and noted to have appetite fluctuations. He/she likes to order out and eat fast food or junk food;' -Interventions included: -Encourage eating nutritionally sound meals; -Hospice consult as indicated; -Occupational therapy, speech therapy to screen, evaluate, and treat as indicated; -Labs as ordered, and report to physician and RD; -Monitor and record food intake at each meal; -Monitor/document/report signs/symptoms of dysphagia (difficulty swallowing); -Notify dietician if meal intake is poor for more than 48 hours -Offer substitutes as requested or indicted. He/she likes fast food; -Supplements as ordered, and notify physician and RD if refused consistently; -The care plan failed to reflect the resident's desired outcome of weight loss; -The care plan failed to describe the resident's ongoing refusal of meals, and action taken by staff to educate the resident regarding alternatives and consequences; -The care plan failed to identify individualized measurable objectives, interventions, and timeframes for how staff will address his/her nutritional status. 2. Review of Resident #21's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Resident rarely/never understood; -Delusions exhibited; -Wandering behavior exhibited 4-6 days, not daily; -[DIAGNOSES REDACTED]. Review of the resident's nurse's notes, showed: -On 10/31/19, staff documented the resident redirected from attempting to open multiple doors on the unit. He/she then walked out of an unsecured door and staff attempted to redirect him/her back inside the facility; -On 12/7/19, staff documented the resident redirected multiple times for attempting to open doors and walk into other resident rooms. Although initially difficult, resident stopped the behavior and was calm through the rest of the shift; -On [DATE], staff documented the resident up wandering throughout night shift, often difficult to redirect. Resident very confused, attempted to exit from the unit's doors. He/she did not sleep on night shift; -On 2/10/20, staff documented the resident wandering in and out of other resident rooms. Constant redirection through the shift. Challenging to redirect. Observations on 3/1, 3/2, 3/3, 3/4, and 3/5/19, showed the resident's room located in the facility's memory care unit. Keypad entry required to enter the unit from other areas of the facility. Doors to exterior clearly marked as Exits. During an interview on 3/5/20 at 7:55 A.M., Certified Nurse Aide (CNA) K said the resident wanders in and out of other resident rooms. Sometimes, he/she gets in other residents' beds. Staff is expected to redirect the resident when he/she wanders. During an interview on 3/5/20 at 8:15 A.M., the MDS Coordinator said he/she is primarily responsible for the resident's care plans. The resident wanders up and down the halls of the unit, but he/she does not have a history of elopement or wandering into other resident rooms. Review of the resident's care plan, undated and in use at the time of survey, showed: -Problem: Is an elopement risk/wanderer (specify) related to dementia. On 8/29/19, observed exit seeking and wanting to go home; -Interventions included: -1:1 observation with 15 minute checks; -Disguise exits: cover door knobs and handles, tape floor; -Distract resident from wandering by offering pleasant activities. Resident prefers: (blank); -Identify pattern of wandering and intervene as appropriate; -Provide structured activities: toileting, walking inside and outside, reorientation strategies; -The care plan failed to document current individualized and measurable objectives, interventions, and timeframes for how staff will address ongoing wandering behavior. 3. Review of Resident #35's quarterly MDS, dated [DATE], showed: -[DIAGNOSES REDACTED]. Review of the resident's progress notes, showed staff documented: -On 12/[DATE]9, the resident refused to shower three times; -On 12/21/19, the resident's family informed of the resident's refusal to shower on that day and on 12/17/19; -On 1/8/20, the resident refused to shower four times; -On 1/18/20, the resident refused to shower three times. Review of the resident's care plan, undated and in use at the time of survey, showed: -Problem: Activities of daily living (ADL) self-care performance deficit; -Interventions: -Bathing/showering: resident is totally dependent on one staff to provide (specify bath/shower)(specify frequency) and as necessary; -Bed mobility: resident requires (specify what assistance) by one staff to turn and reposition in bed (specify frequency) and as necessary; -Toilet use: resident requires (specify assistance) by one staff for personal hygiene and oral care; -Transfers: resident requires (specify what assistance) by one staff to move between surfaces (specify frequency) and as necessary; -The care plan failed to identify individualized objectives, interventions, and timeframes for how staff will address his/her ADL performance deficits and refusal of assistance. 4. During an interview on 3/5/20 at approximately 8:15 A.M., the MDS Coordinator said he/she develops resident care plans based on his/her resident observations, discussions with facility staff, and review of resident records. Comprehensive care plans should be individualized, with interventions specific to the resident. Care plans should be updated to reflect the resident's current needs. 5. During an interview on 3/5/20 at 3:38 P.M., the administrator said she expects resident care plans to be updated and individualized, specific to the resident. The care plan should accurately reflect the resident's current needs.
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 notified two resident's physicians when their blood sugar levels exceeded parameters ordered by those physicians. The facility identified 27 residents that received blood glucose checks, 16 were reviewed, three exceeded the physician's parameters and problems were found with two (Residents #31 and #13). Additionally, the facility failed to ensure staff obtained and documented vital signs and neurological assessments (neurochecks) in accordance with the facility's policy regarding assessing falls, for three residents and failed to notify the physician of laboratory test results and document [MED]gen saturation levels as ordered (Residents #77, #88, #3 and #60). The census was 97. 1. Review of Resident #31's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/18/19, showed: -admission date of [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's Medication Administration Record [REDACTED]. If the blood sugar is greater than 351, notify the physician. Further review of the MAR, showed: 8:00 A.M.: -2/12; 359, 2/15; 383, 2/16; 399, 2/20; 413 and 2/22; 383; 11:00 A.M.: -2/5; 431, 2/6; 430, 2/11; 509, 2/12; 575, 2/13; 453, 2/14; 418, 2/24; 550 and 2/27; 468; -4:00 P.M.: -2/13; 460, 2/17; 455 and 2/18; 438; -Review of the back of the MAR, showed no documentation the physician had been notified regarding the results of any of the above blood sugar results. Review of the resident's progress notes, showed no documentation staff notified the resident's physician regarding the blood sugar levels. During an interview on 3/2/20 at 5:11 P.M., the Director of Nursing (DON) said she could not find documentation staff had notified the resident's physician regarding the blood sugar levels. She would have expected staff to follow the physician's orders [REDACTED].#13's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's MAR, dated 2/1/20 through 2/29/20, showed an order to check the resident's blood sugar four times a day. If the blood sugar is greater than 400, notify the physician. Further review of the MAR, showed: -2/4/20 at 8:00 P.M.: A blood sugar of 417; -No documentation on the back of the MAR indicated [REDACTED]. During an interview on 3/2/20 at 5:06 P.M., the DON said she could not find documentation staff had notified the resident's physician regarding the blood sugar level. She would have expected staff to follow the physician's orders [REDACTED]. hours after an observed of suspected fall, and document findings in the medical record; -Documentation: When a resident falls, the following information should be recorded in the resident's medical record; -The condition in which the resident is found; -Assessment data, including vital signs and any obvious injuries; -Interventions, first aid, or treatment administered; -Notification of the physician and family, as indicated; -Completion of a falls risk assessment. 4. Review of Resident #77's annual MDS, dated [DATE], showed: -Moderate cognitive impairment; -Exhibited no behaviors; -Required limited assistance of one staff for transfers; -[DIAGNOSES REDACTED]. Review of the resident's nurse's note, showed: -On 1/29/20 at 12:55 P.M., the resident observed laying on the floor on his/her left side. Skin assessed with [REDACTED]. No break in skin. Area slightly red. Resident responded that it hurts. Pupils round and reactive to light. Unable to obtain vitals due to movement by resident but staff was able to get temperature. Noted at 100.0. Medication given for fever and possible pain. Power of Attorney contacted. Physician and nurse practitioner paged and awaiting return call. DON aware of situation. Resident currently up in wheelchair near nurse's station. Will continue to monitor and document accordingly; -On 1/30/20 at 11:28 A.M., Resting in bed with call light in reach. All fall precautions in place. No signs and symptoms of pain and no distress noted. Will continue to monitor; -On 1/30/20 at 9:39 P.M., the resident remains on observation related to recent fall. Day one of three. No new bruising or injury noted. Resident was compliant with all meds and daily care. No behaviors this shift; -On 1/31/20 at 5:01 A.M., the resident remains on IFU (incident follow up) fall without any apparent injuries noted. Resident to have vital signs obtained. Denies any pain. Resident resting in bed. Call light within reach; -On 1/31/20 at 11:36 A.M., the resident in room refused all

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) vitals this morning, fall precautions, unable to complete assessment due to resident refusals, will continue to monitor; -No further nurse's notes regarding the fall. Review of the resident's care plan, updated on 2/11/20 and in use during the time of the survey, showed: -Focus: Had an actual fall without injury; -Goal: Resume my usual activities without further incident through the review date; -Interventions: Assist with removing some of the items I carry on my wheelchair, monitor cause for fall. Remind resident to ensure that when he/she is self-transferring, to lock the wheelchair, if no apparent injuries, determine and address causative factors of the fall; -Focus: The resident has had an actual fall with no injury. He/she was getting clothes out of the closet and lost his/her balance; -Goal: The resident will resume usual activities without further incident through the review date; -Interventions: Continue interventions on the at-risk plan, monitor/document/report as needed and for 72 hours to physician signs and symptoms of pain, bruising, change in mental status; -Further review of the care plan, showed no information regarding the fall occurring on 1/29/20. Further review of the resident's medical record, showed no vitals or fall investigation regarding the fall occurring on 1/29/20. During an interview on 3/5/20 at 12:28 P.M., the DON said the post 72 hour check was not completed on the resident regarding the 1/29/20 fall. She would have expected staff to document vitals and update the resident's care plan. 5. Review of Resident #88's quarterly MDS, dated [DATE], showed: -[DIAGNOSES REDACTED]. Review of the resident's medical record, showed: -An incident note, dated 8/26/19 at 12:47 P.M., in which staff documented the resident stated he/she fell in his/her room last night. Observed bruise below side of resident's right eye. Resident stated he/she fell asleep in his/her chair and fell on his/her face with chair on top of him/her; -No documentation of neurochecks completed within 48 hours after the fall; -An incident note, dated 10/1/19 at 11:40 P.M., in which staff documented the resident found on floor next to his/her bed. Resident stated he/she fell asleep and fell out of his/her chair. Observed dark brown area to the resident's right outer eye, without swelling or redness. Resident said the brown area was old; -No documentation of neurochecks completed within 48 hours after the fall; -An incident note, dated 12/[DATE]9 at 3:30 P.M., in which staff documented the resident found on floor in hallway. Resident said he/she fell in the doorway to his/her room and hit his/her head; -No documentation of neurochecks completed within 48 hours after the fall; -An incident note, dated 1/19/20 at 6:07 P.M., in which staff documented the resident observed to lose balance and hit his/her head on a handrail before falling to the floor; -No documentation of neurochecks completed within 48 hours after the fall; -An incident note, dated 1/27/20 at 1:15 P.M., in which staff documented the resident observed nodding off in a chair in the dining room. A few minutes later, staff heard a noise and observed resident laying on the floor in front of the chair. Observed bruise developing on the left side of his/her head; -No documentation of neurochecks completed within 48 hours after the fall. During an interview on 3/5/20 at 10:11 A.M., the Clinical Director reviewed the resident's paper chart and said he/she could not locate neurochecks completed after the resident's falls on 8/26/29, 10/1/19, 12/[DATE]9, 1/19/20 and 1/27/20. Staff should document post-fall vital signs and neurochecks in the resident's chart. 6. Review of Resident #3's quarterly MDS, dated [DATE], showed: -[DIAGNOSES REDACTED]. Review of the resident's nurse's notes, dated 12/13/19 at 8:33 P.M., showed: -Resident sat at the nurse's station in his/her wheelchair; -Leaned forward, fell and hit head. Resident on frequent vital signs with neurochecks from a previous fall; -Will continue neuro checks. No complaints of pain, no bruising, swelling, or skin tears; -No documentation regarding neurochecks. Observation on 3/3/20 at 9:23 A.M., showed the resident lay in bed receiving personal care. During an interview on 3/5/20 at 12:38 P.M., the DON said she was unable to find the neurochecks for the fall/head injury. Staff complete a separate form, neurocheck sheet, and place it in the resident's chart. She would expect the staff to complete them whenever the resident has a head injury from a fall. Review of the resident's nurse's notes, dated 2/12/20 at 6:06 P.M., showed: -CBC (Complete Blood Count, blood test) and BMP (Basic Metabolic Pane, blood test) labs reported to the physician. New orders obtained for iron level, B 12 (blood test), folate level (blood test) and a TIBC (total iron binding test, blood test) to be drawn tomorrow 2/13/20. Review of the medical record, showed no documentation of staff notifying the physician of the laboratory results. During an interview on 3/5/20 at 4:16 P.M., the DON said the laboratory tests were completed as ordered. Staff failed to notify the physician of the results. She would have expected the staff to notify the physician as ordered. 7. Review of Resident #60's POS, dated [DATE] through 3/31/20, showed: -[DIAGNOSES REDACTED]. document the [MED]gen saturation. Observation on 3/5/20 at 6:25 A.M., showed the resident lay in bed, with head of bed up. Oxygen at 5 liters per trachea mask, [MEDICAL CONDITION] dressing clean, tubing and humidifier bottle dated 3/3/20. During an interview on 3/5/20 at 4:18 P.M., the DON said she would expect the staff to document the [MED]gen saturation. MO 315
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff provided necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for pressure ulcers. The facility identified seven residents with pressure ulcers. Six were sampled, and problems were found with one (Resident #195). The census 97. Review of there facility's policy on Prevention of Pressure Ulcer/Injuries, dated 12/2018, showed: -Purpose: The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors; -Risk assessment: #4. Observe the skin on a daily basis when performing or assisting with personal care or activities of daily living; -The policy did not show what staff should do when dressings are soiled or removed when soiled. Review of Resident #195's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/2/20, showed: -[DIAGNOSES REDACTED]. Slough or eschar may be present). Review of the resident's care plan, updated 2/2/20, showed: -Problem: The resident has Stage IV pressure ulcer on his/her coccyx upon admission. Continue to receive daily dressing change to his/her coccyx Stage IV, some improvement noted; Approach: Administer medications as ordered. Monitor/document for side effects and effectiveness. Administer treatments as ordered and monitor for effectiveness. Assess/record/monitor wound healing: Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. Follow facility policies/protocols for the prevention/treatment of [REDACTED]. Document alternative methods. Inform the resident/family/caregivers of any new area of skin breakdown. Teach resident/family the importance of changing positions for prevention of pressure ulcers. Encourage small frequent position changes. The resident needs: with use of bed rails, trapeze bar, etc for resident to assist with turning. Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage). Observation on 3/3/20, showed: -9:49 A.M., showed the resident lay in bed on a soiled incontinence pad. After providing perineal care, Certified Nurse Aide (CNA) H turned the resident to the left side, revealing a large dressing covering the resident's buttocks. A large amount of stool covered the bottom of the dressing. After cleaning the resident's buttocks, CNA H removed dressing revealing a large pressure ulcer approximately 4 centimeters (cm) with depth of 3 cm and placed a clean incontinence pad under the resident. He/she notified the charge nurse at the desk he/she removed the soiled dressing. The charge nurse said to notify the treatment nurse; -12:30 P.M., showed the resident lay in bed resting; -2:20 P.M., showed the resident lay on his/her left side. CNA N was providing care, cleaning stool from around the inside edges of the pressure ulcer. CNA N said there was no dressing on the pressure ulcer. Observation of the incontinence pad showed no dressing. This surveyor asked the treatment nurse to assess the resident's pressure ulcer at this time. During an interview on 3/3/20 at 2:40 P.M., the treatment nurse said staff notified her the dressing was removed this morning after care. At approximately 10:30 A. M., she went to the resident's room to reapply the dressing, but he/she was receiving therapy. The resident had also soiled him/herself. Staff was supposed to let her know when the resident was finished with therapy and received care. The resident should not have been without a dressing covering the pressure ulcer. During an interview on 3/4/20 at 7:04 A.M., CNA H said he/she notified the charge nurse when he/she removed the resident's dressing because it was soiled. The charge nurse asked him/her to notify the treatment nurse because he/she was sending out a resident. He/she notified the treatment nurse. He/she notified the treatment nurse after cleaning the resident at about 10:00 A.M. During an interview on 3/5/20 at 2:00

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) P.M., the Director of Nurses said she would expect the staff to notify the charge nurse and or treatment nurse when a dressing is soiled or comes off. The resident's dressing should not be off for long periods of time.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 ensure staff cleaned one resident's indwelling urinary catheter during personal care and failed to maintain proper positioning of that resident's catheter tubing and bag as well as one other resident's catheter bag. The facility identified seven residents that used catheters, five were sampled and problems were found with two (Residents #36 and #93). The census was 97. 1. Review of Resident #36's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/26/19, showed: -Persistent vegetative state/no discernible consciousness; -Total dependence of two (+) persons required for bed mobility; -Total dependence of one person required for dressing, personal hygiene and bathing; -Indwelling urinary catheter (a tube is inserted through the urethra into the bladder to drain urine from the bladder. The urine drains via the catheter into a drainage bag.); -[DIAGNOSES REDACTED]. Observation on 3/3/20 at 6:30 A.M., showed the resident lay in bed on his/her back. The head of his/her bed was raised and his/her urine drainage bag (catheter bag) was attached to the bed frame approximately 1 foot below the mattress. Certified Nurse Aide (CNA) C, preparing to complete personal hygiene for the resident, lowered the head of the resident's bed, detached the urine drainage bag and placed it next to the resident's right hip. The urine drainage bag and tubing contained clear yellow urine. CNA C washed the resident's genitalia, but failed to wash the catheter from the insertion site to 4 inches outward. At 6:40 A.M., CNA D entered the room to assist CNA C. The CNAs completed the resident's personal hygiene at 7:00 A.M. The resident's urine drainage bag remained on top of the mattress the entire time of the observation. Urine in the tubing was observed flowing back and forth several times as the CNAs moved the urine drainage bag during the care. On two separate occasions, CNA D held the urine drainage bag above the resident's body. During an interview on 3/5/20 at 1:43 P.M., the Director of Nursing (DON) said she expected staff to follow the catheter care policy. The catheter should be cleaned from the insertion site, outward. The catheter bag should not be placed in the bed, it should be left attached to the bed frame, below the bladder. 2. Review of Resident #93's care plan, updated on 12/28/19, showed: -Focus: The resident has a foley catheter; -Goal: The resident will be/remain free from catheter related trauma through review date; -Interventions: Change catheter as ordered, check tubing for kinks each shift, cleanse catheter with soap and water, rinse, pat dry every shift and as needed, monitor and document catheter output each shift. Review of the resident's significant change MDS, dated [DATE], showed: -Rarely understood; -Exhibited no behaviors; -Required total dependence of one staff for personal hygiene; -Indwelling catheter; -[DIAGNOSES REDACTED]. Review of the resident's physician's orders [REDACTED]. Observation on [DATE] at 7:14 A.M., showed the resident lay in bed. His/her catheter bag hung on the left side, facing the resident's bedroom door, of the bed. The bottom of the bag touched the floor. A blue flap covered the front of the catheter bag. No barrier or protective cover surrounded the bag. During an interview on 3/5/20 at 1:38 P.M., the DON said the catheter bags should never touch the floor. There should be a barrier and protective covering surrounding the catheter bag. The current catheter bags had a dignity cover, but no protective barrier. 3. Review of the facility Urinary Catheter Care policy, revised on 9/2014, showed: Purpose: -The purpose of this procedure is to prevent catheter-associated urinary tract infections; Maintaining Unobstructed Urine Flow: -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; Infection Control: -Be sure the catheter tubing and drainage bag are kept off the floor; Steps in the procedure: -Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately 4 inches outward.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement interventions to stabilize or improve nutritional status to acceptable parameters, for one sampled resident identified with severe weight loss (unplanned loss greater than 5% of body weight in one month, greater than 7.5% in three months, or greater than 10% in six months) (Resident #88). The census was 97. Review of Resident #88's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/4/20, showed: -Severe cognitive impairment; -Delusions exhibited; -Rejection of care not exhibited; -Antipsychotic medication used seven of seven days; -No gradual dose reduction (GDR) attempted. GDR not documented by a physician as clinically contraindicated; -No weight loss of 5% or more in the last month or 10% or more in the last six months; -[DIAGNOSES REDACTED]. medical record, showed: -A physician's orders [REDACTED]. -May 2019 weight: 226.2 pounds (lbs); -A pharmacist monthly medication regimen review (MRR), dated 6/12/19, in which irregularities were noted. No documentation specifying which irregularities were noted, the pharmacist's recommendation, or the physician's response; -June 2019 weight: 209.6 lbs; -The resident experienced severe weight loss (unplanned loss of greater than 5% in one month) of 7.34% between May and June 2019. Review of the resident's registered dietician (RD) note, dated 6/26/19, showed the resident noted with weight loss of 16.6 lbs in one month. Staff reported the resident was trying to lose weight, which was positive. No new recommendations. Review of the resident's medical record, showed: -July 2019 weight: 205.6 lbs; -No documentation of RD notes completed in July 2019; -August 2019 weight: 186.4 lbs; -The resident experienced severe weight loss of 9.07% between July and August 2019. Review of the resident's annual nutrition assessment, dated 8/2/19, showed the RD documented an unplanned significant weight loss of 11.3% in the past five months. Resident trying to lose weight, which was positive. Regular LCS diet continues to meet needs. No new recommendations. Review of the resident's RD note, dated 8/26/19, showed the resident triggered for significant weight loss of 12.8% in three months. Resident weighed 197.2 lbs, and still obese. He/she desired weight loss. Fair appetite noted. Staff reported resident refused meals at times, but ate junk food/fast food and soda all day long. The resident used to eat all his/her meals, as well as junk food and soda, so weight loss is likely related to decreased caloric intake from meals. Encouraged resident to eat meals and not junk/fast food and soda. No new recommendations. Review of the resident's progress notes, dated 8/27/19, showed a pharmacist MRR completed with irregularities noted. No documentation specifying which irregularities were noted, the pharmacist's recommendation, or the physician's response. Review of the resident's medical record, showed: -September 2019 weight: not documented; -A dietary order, dated 9/6/19, for health shakes with all meals for weight loss; -A nurse's note, dated 9/11/19, in which staff documented the resident refused the health shake at breakfast and stated he/she was trying to lose weight not gain weight; -A nurse's note, dated 9/15/19, showed the resident consumed 50% of his/her meal at breakfast and 0% at lunch. He/she refused health shakes and bought snacks from the vending machine; -October 2019 weight: 170.4 lbs; -The resident experienced a severe weight loss (unplanned loss of greater than 7.5% in three months) of 8.58% between August and October 2019. Review of the resident's RD note, dated 10/21/19, showed the resident noted with significant weight loss. Resident desired weight loss and refused health shakes. Staff reported the resident eats junk food from the vending machine. Staff encouraged him/her to eat meals, not from the vending machine, but he/she still does it. Recommended to discontinue health shakes. No new supplements or interventions recommended. Review of the resident's progress notes, dated 10/30/19, showed: -A pharmacist MRR completed with irregularities noted. No documentation specifying which irregularities were noted, the pharmacist's recommendation, or the physician's response. -At 10:42 A.M., staff documented a care plan meeting was held. The resident noted to have weight loss and to refuse supplements. Fair appetite noted. Resident liked snacking, rather than eating the ordered diet; -At 2:09 P.M., staff documented the resident refused breakfast and lunch. He/she ate other food (hog head cheese) brought in by his/her family. Review of the resident's care plan, undated and in use at the time of survey, showed: -Problem: Impaired nutritional status. Unplanned/unexpected weight loss related to poor food intake. Has [DIAGNOSES REDACTED]. Has had a medication adjustment and noted to have appetite fluctuations. He/she likes to order out and eat fast food or junk food; -Interventions included: -Encourage eating nutritionally sound meals; -Hospice consult as indicated; -Occupational therapy, speech therapy to screen, evaluate, and treat as indicated; -Labs as ordered, and report to physician and RD; -Monitor and

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OAKWOOD ESTATES NURSING & REHAB	5303 BERMUDA DRIVE NORMANDY, MO 63121

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 0692 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 6) record food intake at each meal; -Monitor/document/report signs/symptoms of dysphagia (difficulty swallowing); -Notify dietician if meal intake is poor for more than 48 hours -Offer substitutes as requested or indicted. He/she likes fast food; -Supplements as ordered, and notify physician and RD if refused consistently; -The care plan failed to reflect the resident's desired outcome of weight loss; -The care plan failed to describe the resident's ongoing refusal of meals, and action taken by staff to educate the resident regarding alternatives and consequences; -The care plan failed to identify individualized measurable objectives, interventions, and timeframes for how staff will address his/her nutritional status. Review of the resident's medical record, showed: -A nurse's note, dated 11/4/19, in which staff documented the resident observed banging his/her head on the dining room table. Resident sent to hospital for assessment; -A nurse's note, dated 11/6/19, in which staff documented the resident returned to facility from hospital with [DIAGNOSES REDACTED]. Review of the resident's nutritional assessment, completed by the RD, dated 11/20/19, showed: -Resident readmitted to facility with orders for regular texture, NAS LCS diet; -Fair appetite noted; -No current nutritional supplement; -No documentation of resident's likes/dislikes; -No new recommendations. Review of the resident's medical record, showed: -No documentation of a pharmacist MRR completed in November 2019; -No documentation of a pharmacist MRR completed in December 2019; -No documentation of RD notes completed in December 2019; -December 2019 weight: 164.0 lbs; -The resident experienced a severe weight loss (unplanned loss of greater than 10% in six months) of 21.76% between June and December 2019. Review of the resident's nurse's notes, dated 1/7/20 and 1/22/20, showed staff documented the resident continued to skip meals and to eat junk food. Review of the RD note, dated 1/22/20, showed the resident noted with significant weight loss of 34.8 lbs in over five months. The resident only lost 2.8 lbs in the past two months, so weight probably stabilizing. Resident continues to consume little of his/her meals and refuse all supplements. Continues to drink soda and eat junk food. Staff to continue encouraging resident to eat meals and not junk food, but poor compliance expected. No new recommendations. Review of the resident's monthly weights, showed: -January 2020 weight: 162.4 lbs; -February 2020 weight: 141.6 lbs; -The resident experienced a severe one month weight loss of 12.81% between January and February 2020. Review of the resident's medical record, showed: -On 1/27/20, the resident's primary physician, Physician L, documented a visit with the resident related to a fall. Resident noted with new or worsening medical problems over the last month. Plan: Continue physical/occupational therapy for gait disorder with falls due to poor judgment, deconditioning, and stroke. No documentation regarding nutritional status; -On 2/13/20, the Nurse Practitioner (NP) from Physician L's office, documented the resident's poor appetite and weight loss. Plan: Labs ordered and referred to neurologist; -On 2/26/20, a different physician from Physician L's office, documented a visit with the resident for malignancy follow-up. Resident asked for donuts, but had decreased appetite. Resident refused lab work ordered by NP on 2/13/20. Malignancy follow-up not feasible. Hospice recommended. Observation of the resident, showed: -On 3/3/20 at 1:30 P.M., he/she was escorted by staff to the vending machine, where he/she bought two bags of chips, a candy bar, and a soda; -On 3/4/20 at 7:48 A.M., he/she was served breakfast. He/she ate without difficulty and consumed approximately 50% of his/her meal; -On 3/5/20 at 8:05 A.M., he/she was served pancakes and a sausage patty for breakfast. He/she ate without difficulty and consumed approximately 50% of his/her meal; -On 3/5/20 at 1:10 P.M., he/she wandered around the dining room with a soda and bowl of vanilla ice cream. The resident said he/she likes vanilla ice cream. The resident approached the nurse's station and attempted to hit a staff member. Staff intervened and redirected the resident to a dining room table. The resident calmed down and ate his/her ice cream. During an interview on 3/5/20 at 5:45 A.M., Certified Medication Technician (CMT) I said the resident has mental health [DIAGNOSES REDACTED]. The resident has lost a lot of weight. He/she does not eat much during meals, but likes other foods, such as burgers and fries. The resident snacks on food several times during a shift, instead of eating one meal. He/she is on a diabetic diet, but eats food from the vending machine. The CMT did not know if a different diet had been attempted. During an interview on 3/5/20 at 8:10 A.M., Certified Nurse Aide (CNA) K and Nurse J said the resident has declined over the past year. He/she buys food from the vending machine, but doesn't eat what he/she purchases. His/her appetite is poor, and it is difficult to determine what he/she will eat. CNA K and Nurse J did not know if the resident's physician or RD had ever recommended an appetite stimulant. During an interview on 3/5/20 at 3:10 P.M., the RD said when the resident first started losing weight, the RD thought it was acceptable. The resident was obese and expressed a desire to lose weight. He/she seemed to become obsessed with weight loss, because staff started reporting the resident refused to eat. The RD ordered the resident to receive health shakes for approximately one month, but the resident refused them. The RD could not recall other interventions attempted. She thought staff might have tried giving the resident supplemental frozen treats. Any intervention attempted by staff should be documented in the resident's record. The RD relies on staff to tell her what the resident likes/dislikes, and will/won't do. The resident's eating habits seem to be a behavioral issue due to his/her mental health. He/she is on a diabetic diet, but does not eat meals served. A change in the type of diet ordered would unlikely result in the resident eating, because he/she prefers to eat junk food. If a resident has significant weight loss, the RD conducts a nutritional assessment and makes recommendations. Facility staff is responsible for notifying the resident's physician of the RD's recommendations, and the physician either accepts or rejects them. During an interview on 3/5/20 at 12:30 P.M., the Director of Nurses (DON) said she could not locate the resident's physician's progress notes from June through December 2019. She could not locate the resident's missing monthly pharmacy MRR, either. Without the pharmacy consults, she was unable to say whether the physician received the recommendations, or agreed with them. The pharmacy consults and physician documentation should be in the resident's medical record. During an interview on 3/5/20 at 2:01 P.M., the DON said when a resident experiences significant weight loss, multiple interventions should be attempted to improve nutritional status. The resident received health shakes for approximately one month, but he/she did not like them. He/she has orders for a diabetic diet, but he/she does not like the food served and eats junk food from the vending machine. The DON did not know if interventions of a non-diabetic diet, double portions, or appetite stimulants had been attempted. If an intervention was attempted but unsuccessful, it should be documented on the resident's care plan. Recently, the DON spoke to the resident's psychiatrist and some of the resident's [MEDICAL CONDITION] medications were reduced. However, the resident continues to have behavioral symptoms and will require continued use of [MEDICAL CONDITION] medication. During an interview on 3/5/20 at 3:38 P.M., the administrator said the resident was just placed on hospice in hopes of the extra attention bringing about a bounce-back from his/her decline. The resident's psychiatrist thought one of the resident's medications contributed to his/her weight loss, so that medication was recently discontinued. All nutritional interventions should be documented in the resident's medical record, and his/her care plan should be updated. Care plans should be individualized for each resident. During an interview on 3/10/20 at 11:19 A.M., Social Worker M, employed with Physician L's office, said the physician was not in the office at that time. She spoke to the resident's physician and completed a review of the resident's chart regarding nutritional status. The resident became Physician L's patient in September 2019. Facility staff did contact the physician's office regarding the resident's weight loss and refusal to eat meals; however, they did not report the resident's preference to snack throughout the day and to eat food from the vending machine. The physician's office has not received recommendations from the RD, or from the pharmacist's monthly medication regimen reviews. It is expected for recommendations from the RD and the pharmacist to be communicated to the physician. The physician's office contacted the facility and requested they provide all RD and pharmacy recommendations to the physician's office on a monthly basis. The resident was referred to hospice due to his/her weight loss. MO 315
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 two residents with tube feedings had their tube feeding pumps placed on hold or turned off prior to having the heads of their beds laid flat to receive personal care. The facility identified six residents as having a tube feeding. Four of those residents were sampled and three were observed receiving personal care. Of those three observations, problems were identified with two (Residents #3 and #75). The census was 97. 1. Review of Resident #3's quarterly Minimum Data Set (MD'S), a federally mandated assessment instrument completed by facility staff, dated 11/19/19, showed: -[DIAGNOSES REDACTED]. Review of the resident's physician's orders [REDACTED]. Observation on 3/3/20 at 9:23 A.M., showed the resident lay flat in bed receiving personal care. His/her tube feeding of [MEDICATION NAME] 1.2 continued to infuse at 75 cc per hour. The resident remained flat in the bed while Certified Nurse Aide (CNA) O applied his/her pants and shirt. He/she helped the resident sit on the side of bed, disconnected the running tube feeding and hooked the tubing on the pump. 2. Review of Resident #75's quarterly MD'S, dated

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) 1/24/20, showed: -Rarely/never understood or understands; -Total dependence of one person required for bed mobility and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 1/5/20, showed: -[DIAGNOSES REDACTED]. Observation on 3/3/20 at 5:30 A.M., showed the resident lay flat on his/her back with his/her tube feeding on and infusing. CNA D was in the process of finishing personal care with the resident. During an interview at that time, the CNA said he/she had just turned the resident's tube feeding pump on prior to the surveyor entering, because he/she was almost finished with the resident's care. He/she was going to raise the head of the bed back up in a couple of minutes. He/she acknowledged he/she should have waited until he/she was completely finished and the head of the bed was up before turning the tube feeding pump back on. 3. During an interview on 3/5/20 at 1:43 P.M., the Director of Nursing said only nurses are authorized to turn the tube feeding pumps on or off or on hold. Tube feeding should be turned off prior to laying a resident down in bed to prevent aspiration (tube feeding or saliva are breathed into the airway). The tube feeding should not be turned back on until the head of the bed is back up.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents with a [MEDICAL CONDITION] were provided care consistent with professional standards of practice. Staff failed to notify the nurse of one resident who required suctioning and failed to change that resident's humidified air bottle as ordered. The facility identified two residents with [MEDICAL CONDITION]'s, both were sampled and problems were identified with one (Resident #36). The census was 97. Review of Resident #36's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/26/19, showed: -Persistent vegetative state/no discernible consciousness; -Total dependence of two (+) persons required for bed mobility; -Total dependence of one person required for dressing, personal hygiene and bathing; -Oxygen therapy; -Tracheotomy (a surgical incision into the trachea (wind pipe)), [MEDICAL CONDITION] care and suctioning (a tube is inserted into the [MEDICAL CONDITION] to suction mucus and phlegm from the trachea and lower airway - [DIAGNOSES REDACTED]. Observation on [DATE] at 7:30 A.M., showed the resident lay in bed with head of bed elevated. The tracheal (trach) mask (a plastic mask that fits over the tracheotomy site that infuses [MED]gen into the tracheotomy) with flexible tubing was connected to a high humidity bottle (a bottle filled with distilled water, used to moisturize the [MED]gen). The high humidity bottle was dated 2/17/20. Observation on 3/3/20 at 6:30 A.M., showed the resident lay in bed on his/her back. The head of his/her bed was raised. The resident had a large amount of mucus visible inside his/[MEDICAL CONDITION]. The resident had audible gurgling. Certified Nurse Aide (CNA) C, preparing to complete personal hygiene for the resident, lowered the head of the resident's bed, and laid the resident flat on his/her back. For approximately the first 10 minutes of the observation, [MEDICAL CONDITION] was observed to have a build-up of mucus and the resident made a wet gurgling noise with each breath. Eventually the resident coughed hard enough he/she expelled the majority of the mucus from the tracheotomy. A large amount of clear mucus was observed on the resident's pillow case after the cough and expulsion. After the expulsion of mucus, the resident no longer made gurgling noises with each breath. Observation on 3/4/20 at 8:30 A.M., showed the resident sat in gerichair (reclining wheeled chair) at the bedside. [MEDICAL CONDITION] with flexible tubing was attached to the humidity bottle. The high humidity bottle was dated 3/3/20. During an interview on 3/5/20 at 6:27 A.M., Nurse B said he/she changed the humidified bottles and tubing weekly. He/she was unaware the humidity bottle was dated 2/17/20. During an interview on 3/5/20 at 1:43 P.M., the Director of Nursing (DON) said if the resident had visual secretions in the trachea mask and audible gurgling, the resident should have remained upright, and the CNA should have informed the nurse so the resident could have the secretions suctioned from the tracheotomy prior to being laid flat. During an interview on 3/5/20 at 5:16 P.M., the DON said the standard of practice is to change the humidifier bottles and tubing weekly.
F 0698 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to routinely assess, monitor and document on two residents receiving [MEDICAL TREATMENT] (process for removing toxins from the blood for individuals with kidney failure) regarding their shunts (artificial link between an artery and a vein) and/or fistulas (connection between a real artery and vein). The facility identified five residents as receiving routine [MEDICAL TREATMENT] treatments, two were sampled and problems were found with both. (Residents #61 and #70). The census was 97. 1. Review of Resident #61's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/16/20, showed: -Rarely understood; -Exhibited no behaviors such as rejection of care; -[DIAGNOSES REDACTED]. Review of the resident's undated care plan, in use during the time of the survey, showed: -Focus: Needs [MEDICAL TREATMENT] due to end stage [MEDICAL CONDITION] on Monday, Wednesday and Friday; -Goal: Will have minimized risk of complications related to [MEDICAL TREATMENT] through the review date; -Interventions: Auscultate (listen with a stethoscope) bruit (a vascular murmur and an indicator of how well the [MEDICAL TREATMENT] access is functioning) and palpate thrill (a vibration or buzzing and should be detected) every shift. Notify physician of abnormalities, check and change dressing daily at access site. Document. Do not draw blood or take blood pressure in arm with graft, monitor and treat for side effects, monitor vital signs before and after [MEDICAL TREATMENT], monitor/document report to physician symptoms and signs of depression, monitor/document/report new/worsening [MEDICAL CONDITION], weight gain, monitor/document/report any signs and symptoms of infection to access site. Review of the resident's physician's orders [REDACTED]. During an interview on 3/4/20 at 9:15 A.M., Nurse A said the assessments for [MEDICAL TREATMENT] residents should be documented before and after each [MEDICAL TREATMENT] session. It should be documented on the nurse's Medication Administration Record [REDACTED]. Review of the resident's nurse MAR, dated [DATE] through 3/31/20, showed no information regarding what days the resident attended [MEDICAL TREATMENT], the location of the shunt/fistula or what and how often staff should monitor/assess the shunt/fistula. 2. Review of Resident #70's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Total dependence of one person required for bed mobility, locomotion on/off the unit, dressing and personal hygiene; -[DIAGNOSES REDACTED]. Review of the resident's care plan, dated 1/13/20, showed: -Received [MEDICAL TREATMENT] three times a week on Tuesday, Thursday and Saturday; -Auscultate the bruit palpate thrill every shift, notify the physician if absent or abnormal; -Monitor for side effects: Cramping, fatigue, headaches, itching, and [MEDICAL CONDITION]; -Monitor vital signs before and after [MEDICAL TREATMENT]. Notify physician of abnormalities; -Monitor/document/report as necessary any signs or symptoms of bleeding, hemorrhage, bacteremia (infection); -Monitor/document/report: Altered mental status, changes in skin conditions or respiratory status. Review of the resident's POS, dated [DATE] through 3/31/20, showed no order for [MEDICAL TREATMENT], where the [MEDICAL TREATMENT] takes place or what days and times, the site of the shunt/fistula, or how often an assessment should be completed. Review of the resident's progress notes, from 1/1/20 through 2/29/20, showed staff failed to document a post [MEDICAL TREATMENT] assessment for 20 of 27 [MEDICAL TREATMENT] sessions. 3. During an interview on 3/5/20 at 7:50 A.M. and 2:03 P.M., the Director of Nursing said staff should be documenting a post [MEDICAL TREATMENT] assessment after each [MEDICAL TREATMENT] session on the MAR. She could not find post [MEDICAL TREATMENT] assessments for Residents #61 or #70. Although nurses documented some post assessments in the nurse's progress notes, they were not consistent documenting the assessment after each [MEDICAL TREATMENT] session. The nurses should be documenting the post [MEDICAL TREATMENT] assessments on the nurse's MAR. The nurses were expected to do a post [MEDICAL TREATMENT] assessment after each session.

F 0700 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.** **Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.**

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F 0700 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure five of five residents sampled and observed using side (bed) rails had assessments that addressed alternatives attempted prior to the installation of the side rails, including the risk of entrapment. One resident, was observed with his/her left shoulder and left arm wedged between the side rail and the mattress. Four other residents had no assessments and no physician orders for the side rails. The facility identified seven residents that used side rails, five were sampled and problems were found with all five. (Residents #14, #93, #17, #61 and #18). The census was 97. Review of the facility's Restraints-Side Rails policy, revised on 6/2019, showed: Purpose: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms; -Definition: Physical restraints are defined by the Centers for Medicare and Medicaid Services (C[CONDITION]) as any manual method or physical or mechanical device, material, or equipment attached of adjacent to the resident's body that the individual cannot remove easily which restrict freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.); -General Guidelines: 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed.) (Note: The side rails may have the effect of restraining one individual and not the other, depending on the individual resident's condition and circumstances.) 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident's care plan. 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. 6. Less restrictive interventions that will be incorporated in care planning include: a. Providing restorative care to enhance abilities to stand safely and to walk; b. Providing a trapeze to increase bed mobility; c. Equipping the resident with a device that monitors attempts to arise; e. Providing staff monitoring at night with periodic assisted toileting for residents who can comprehend this information. 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rails will be obtained from the resident or legal representative, after presenting potential benefits and risks. (Note: Federal regulations do not require written consent for using restraints. Signed consent forms do not relieve the facility from meeting the requirements for restraint use, including proper assessment and care planing. While the resident or family (representative) may request a restraint, the facility is responsible for evaluating the appropriateness of that request.) 10. Manufacturer instructions for the operation of side rails will be adhered to. 11. The resident will be checked periodically for safety relative to side rail use. 12. If the side rail use is associated with symptoms of distress, such as screaming or agitation, the resident's needs and use of side rails will be reassessed. 13. When side rail usage is appropriate, the facility will access the space between the mattress and side rail to reduce the risk of entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used). 14. Side rails with padding may be used to prevent resident injury in situations of uncontrollable movement disorders, but are still restraints if they meet the definition of a restraint. 15. Facility staff, in conjunction with the Attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions. 1. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/2[DATE]9, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated 11/2[DATE]9, showed the following: -Problem: Risk for falls related to (r/t) daily use of [MEDICAL CONDITION] drug use, increased anxiety and restlessness. Resident has had a fall from his/her bed, no injury r/t frequent movement; - Approach: Check range of motion (Specify #) times daily. For no apparent acute injury, determine and address causative factors of the fall. Monitor/document /report as needed (PRN) x 72 hours to physician for signs and symptoms of pain, bruises and changes in mental status. New onset: confusion, sleepiness, inability to maintain posture, agitation. - Place my side rails up X 2 for safety. Review of the resident physician's order sheet (POS), dated [DATE] though 3/31/20, showed an order for [REDACTED]. Review of the resident's medical record, showed no side assessment was completed. Observation on [DATE], at 7:16 A.M., 7:20 A.M., 7:20 A.M., and 7:23 A.M., showed the resident with his/her left shoulder and arm wedged between the mattress and half side rail on the left side; -7:26 A.M.: Nurse passed the resident's room on his/her way to the nurse's station. Walked back, looked in the room, went in and straightened the resident onto the center of the mattress. He/she lay on a bare mattress, without a sheet, moving his/her legs up and down. The side rails were raised on both sides; -8:30 A.M.: The resident was slumped over to the left of the bed, leaning against the side rail. 2. Review of Resident #93's physician's order sheet, dated February 2020, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated on 2/3/20, showed no information regarding the use of side rails. Review of the resident's significant change MDS, dated [DATE], showed: -Rarely understood; -Required limited assistance of one staff for bed mobility; -Required extensive assistance of two staff for transfers; -Bed rails (side rails) not used. Further review of the resident's electronic and paper medical record, showed no side rail assessment. Review of the resident's POS, dated March, 2020, showed an order, dated 3/4/20 for side rails per family request to aid in bed mobility and repositioning. Observations on [DATE] at 7:14 A.M., 3/2/20 at 6:50 A.M. and 3/4/20 at 6:57 A.M., showed the resident lay in a low bed. Quarter side rails were raised in a horizontal position on both sides of the bed. 3. Review of Resident #17's admission MDS, dated [DATE], showed: -Rarely understood; -Required total dependence of two staff for bed mobility and transfers; -Bed rails not used. Review of the resident's POS, dated February 2020, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated on 2/19/20, showed no information regarding the use of side rails. Further review of the resident's electronic and paper medical record, showed no side rail assessment. Observations on [DATE] at 7:14 A.M., 3/2/20 at 6:54 A.M., 3/3/20 at 6:55 A.M., and 3/4/20 at 6:59 A.M., showed the resident lay in bed. One half side rails were raised in a horizontal position on both sides of the bed. Review of the resident's POS, dated March 2020, showed an order, dated 3/4/20 to discontinue the use of side rails due to non-use in mobility and positioning. 4. Review of Resident #61's significant change MDS, dated [DATE], showed: -Rarely understood; -Required limited assistance of one staff for bed mobility and transfers; -Bed rails not used. Review of the resident's POS, dated February 2020, showed: -[DIAGNOSES REDACTED]. Review of the resident's undated care plan, showed no information regarding the use of side rails. Further review of the resident's electronic and paper medical record, showed no side rail assessment. Observations on [DATE] at 7:14 A.M., 3/2/20 at 6:55 A.M., 3/3/20 at 6:56 A.M. and 3/4/20 at 7:00 A.M., showed the resident lay in bed. Quarter side rails were raised in a horizontal position on both sides of the bed. 5. Review of Resident #18's quarterly MDS, dated [DATE], showed: -Limited assistance of one person required for bed mobility; -Total dependence of two (+) persons required for transfers; -[DIAGNOSES REDACTED]. Review of the resident's POS, dated [DATE] through 3/3/20, showed no order for side rails. Observation on 3/2/20 at 6:12 A.M., showed the resident lay in bed with two quarter length side rails up, one on each side at the head of the bed. Observation on 3/4/20 at 8:23 A.M. and at 11:22 A.M., showed the resident lay in bed with two quarter length side rails up, one on each side at the head of the bed. Review of the resident's POS, dated [DATE] through 3/31/20, showed a hand written order dated 3/4/20, for the resident to use side rails to aid in bed mobility and repositioning. Review of the resident's medical record, showed no bed rail assessment for the resident's use of side rails. 6. During an interview on 3/4/20 at 9:15 A.M., Nurse A said the side rails for residents were used for positioning and mobility. Assessments were completed and placed in the electronic medical record. They were completed quarterly and the nurses were responsible for completing the assessments. 7. During interviews on 3/4/20 at 12:55 P.M. and 3/4/20 at 7:41 A.M., the administrator and Director of Nursing said side rail assessments were not done for any of the residents. The assessments should have been completed, care planned and an order should have been obtained by the physician.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.**

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OAKWOOD ESTATES NURSING & REHAB	5303 BERMUDA DRIVE NORMANDY, MO 63121

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 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 9) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident medication regimen reviews (MRR) were completed by a licensed pharmacist on a monthly basis, and to document the physician's response to irregularities noted, for four of 20 sampled residents (Residents #88, #35, #78, and #80). The census was 97. 1. Review of Resident #88's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/4/20, showed: -[DIAGNOSES REDACTED]. a physician as clinically contraindicated; -Medication follow-up: not addressed/no information. Review of the resident's care plan, undated and in use at the time of survey, showed: -Focus: Falls; Has actual/potential for falls related to [DIAGNOSES REDACTED]. Review of the resident's medical record, showed: -On 6/12/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 7/29/19, MMR completed with no recommendations; -On 8/27/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 9/25/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 10/30/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -No documentation of MMR completed in November [DATE] -No documentation of MMR completed in December 2019. 2. Review of Resident #35's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -Delusions exhibited; -[DIAGNOSES REDACTED].-up: not assessed/no information. Review of the resident's care plan, undated and in use at the time of survey, showed: -Focus: Has depression related to mood; -Interventions included pharmacy review monthly or per protocol. Review of the resident's medical record, showed: -On 10/31/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -No documentation of MMR completed in November [DATE] -No documentation of MMR completed in December [DATE] -No documentation of MMR completed in January 2020. 3. Review of Resident #78's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -[DIAGNOSES REDACTED]. follow-up: not assessed/no information. Review of the resident's medical record, showed: -On 5/22/19, MMR completed with recommendation to attempt GDR for antidepressant medication; -No documentation of physician response; -On 6/12/19, MMR completed with recommendation to obtain labs; -Labs completed as recommended; -On 7/29/19, MMR completed with no recommendations; -On 8/27/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 9/25/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 10/31/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -No documentation of MMR completed in November [DATE] -No documentation of MMR completed in December 2019. 4. Review of Resident #80's quarterly MDS, dated [DATE], showed: -admitted on [DATE]; -[DIAGNOSES REDACTED]. Review of the resident's medical record, showed: -On 5/22/19, MMR completed with recommendation to change blood pressure medication and attempt GDR for one antidepressant medication and one antipsychotic medication; -No documentation of physician response; -On 6/12/19, MMR completed with recommendation to obtain labs; -Labs completed as recommended; -On 7/29/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 8/27/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 9/25/19, MMR completed with irregularities noted; -No documentation of pharmacist recommendations or physician response; -On 10/30/19, MMR completed with no recommendations; -No documentation of MMR completed in November [DATE] -No documentation of MMR completed in December 2019. 5. During an interview on 3/5/20 at 12:30 P.M., the Director of Nurses (DON) said the monthly pharmacist MRRs could not be located. The pharmacist used to email their recommendations to the facility's Assistant Director of Nurses (ADON); however, the ADON no longer works at the facility. Without having documentation of the MRRs, it could not be determined whether the physician accepted or declined the pharmacist's recommendations. MO 315
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a system in place to ensure 'as needed' (PRN) orders for [MEDICAL CONDITION] drugs were limited to 14 days, or to document rationale for extending PRN orders beyond 14 days in the resident's medical record, for one of 20 sampled residents (Resident #21). The census was 97. Review of Resident #21's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 12/11/19, showed: -admitted on [DATE]; -[DIAGNOSES REDACTED]. by physician as clinically contraindicated. Review of the resident's physician's orders [REDACTED]. (antianxiety medication) 0.5 mg tablet, one tablet by mouth four times daily, PRN for agitation; -An order, dated 8/28/19, for [MEDICATION NAME] 2 mg/ml, inject 0.25 ml intramuscularly four times daily, PRN for agitation. Review of the resident's treatment administration record (TAR) for December 2019, showed: -[MEDICATION NAME] 5 mg/ml, 0.2 ml injected intramuscularly, administered one time on 12/5, 12/6, 12/10, and 12/13; -[MEDICATION NAME] 1 mg tablet, administered one time on 12/10 and 12/13; -[MEDICATION NAME] 0.5 mg tablet, administered four times on 12/6, and one time on 12/13; -[MEDICATION NAME] 2 mg/ml, 0.25 ml injected intramuscularly, administered one time on 12/5, 12/10, 12/13, and 12/17, and administered two times on 12/22; -No documentation on back of TAR regarding the reason for PRN medication administration, or the resident's response to treatment. Review of the resident's January 2020 TAR, showed: -[MEDICATION NAME] 5 mg/ml, 0.2 ml injected intramuscularly, not administered; -[MEDICATION NAME] 1 mg tablet, administered one time on 1/7; -[MEDICATION NAME] 0.5 mg tablet, administered one time on 1/7 and 1/30; -[MEDICATION NAME] 2 mg/ml, 0.25 ml injected intramuscularly, administered one time on 1/31. Review of the resident's progress notes, showed: -On 1/31/20, staff documented they left a voicemail for the physician to advise the resident has orders for PRN [MEDICATION NAME] and PRN [MEDICATION NAME]. Awaiting return call to obtain stop date for the medication; -On 2/3/20 at 1:33 P.M., staff documented the resident received PRN [MEDICATION NAME] that morning, due to increased wandering and staff unable to easily redirect; -On 2/18/20 at 2:51 P.M., staff documented the resident received PRN [MEDICATION NAME] due to agitation and wandering, unable to redirect. Review of the resident's February 2020 TAR, showed: -An order, dated 8/29/19, [MEDICATION NAME] 5 mg/ml, 0.2 ml injected intramuscularly four times daily PRN, discontinued 2/12/20. Medication not administered during the month; -An order, dated 8/29/19, for [MEDICATION NAME] 1 mg tablet, one tablet by mouth four times daily PRN, discontinued on 2/12/20. Medication not administered during the month; -An order, dated 8/29/19, for [MEDICATION NAME] 0.5 mg tablet, one tablet by mouth four times daily PRN, discontinued on 2/12/20. Medication administered on 2/3 and 2/5; -An order, dated 8/29/19, for [MEDICATION NAME] 2 mg/ml, inject 0.25 ml intramuscularly four times daily PRN, discontinued 2/12/20. Medication not administered during the month; -No documentation of [MEDICATION NAME] administered on 2/18/20, as documented in the progress note. During an interview on 3/5/20 at 9:15 A.M., the Director of Nurses said while reviewing the resident's chart a few weeks ago, she discovered the resident had standing orders for PRN [MEDICATION NAME] and PRN [MEDICATION NAME], both of which exceeded 14 days. PRN [MEDICAL CONDITION] drugs should only be ordered for 14 days. After 14 days, the use of PRN [MEDICAL CONDITION] drugs should be reassessed, and the physician must issue new orders.
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.** Based on observation and interview, the facility failed to ensure staff were writing the date of opening, on [MED] pens and vials and failed to ensure unopened [MED] pens were stored in the refrigerator. The facility identified five medication carts. Three were observed and problems were identified in all three. The census was 97. Review of the facility Storage of Medications policy, revised on 4/2007, showed: Policy statement: -The facility shall store all drugs and biologicals in a

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 10) safe, secure, and orderly manner; Policy Interpretation and Implementation: -Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received; -The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; -The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy; -Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems; -Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurse's station or other secured location. Observation on [DATE] at 7:12 A.M., of the [LOC] Nurse's medication cart, showed two [MED] pens and one opened vial of [MED]. The two opened [MED] pens had the date of opening written on them. The opened [MED] vial had no date indicating when it was opened. Observation on [DATE] at 7:15 A.M., of the 200 Hall Nurse's medication cart, showed two opened [MED] pens and one opened [MED] vial. All three had no date indicating when they were opened. During an interview at that time, Nurse A, who had observed the [MED]s on both the 100 and 200 medication carts, said the facility policy is to write the date of opening on the [MED] pen or vial and discard the [MED] in 28 days if it has not been used. If the date of opening is not written on the container, you would not know when to discard the [MED]. Observation of [DATE] at 7:15 A.M., of the 300 Hall Nurse's medication cart, showed 15 [MED] pens. Four of the [MED] pens had not been opened and 11 had been opened but had no date of opening written on them. Nurse E confirmed the observations and said the policy is to discard [MED] in 28 days after opening. If the date of opening is not written on the pen you will not know when to discard it. During an interview on [DATE] at 9:09 A.M., the administrator said [MED] that has not been opened should be stored in the refrigerator. [MED] that has been opened should have the date they were opened written on the container. [MED] needs to be discarded within 28 to 30 days after opening if it has not been used. If staff do not write the date on the container, they will not know the discard date.
F 0825 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide or get specialized rehabilitative services as required for a resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents receiving restorative nursing programs (Restorative Therapy (RT)) received RT as ordered. The facility identified 11 residents as receiving RT, six were sampled and problems were found with all six (Residents #2, #83, #14, #75, #60 and #92). The census was 97. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/11/20, showed: -admission date of [DATE]; -Total dependence of one person required for bed mobility, dressing, toilet use, personal hygiene and bathing; -Total dependence of 2 (+) persons required for transfers; -[DIAGNOSES REDACTED]. Review of the resident's RT treatment record, dated 2/1/20 through 2/29/20, showed: -An order dated 10/1/19, for RT five times a week for gait (walking) training; -Further review of the record, showed staff documented the resident received the program 10 out of 20 possible days. 2. Review of Resident #83's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Total dependence of one person required for bed mobility, dressing, toilet use, personal hygiene and bathing; -Total dependence of 2 (+) persons required for transfers; -[DIAGNOSES REDACTED]. Review of the resident's RT treatment record, dated 2/1/20 through 2/29/20, showed: -An undated order for RT maintenance program three times a week; -Further review of the record, showed staff documented the resident received the program five out of 12 possible days. 3. Review of Resident #14's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Extensive assistance of one person required for bed mobility; -Total dependence of 2 (+) persons required for transfers; -Total dependence of one person required for dressing, eating, personal hygiene and eating; -[DIAGNOSES REDACTED]. Review of the resident's RT treatment record, dated 2/1/20 through 2/29/20, showed: -An order dated 9/10, for range of motion three times a week; -Further review of the record, showed staff documented the resident received the program five out of 12 possible days. 4. Review of Resident #75's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Total dependence of one person required for bed mobility, dressing, eating, toilet use, personal hygiene and bathing; -Total dependence of 2 (+) persons required for transfers; -[DIAGNOSES REDACTED]. Review of the resident's RT treatment record, dated 2/1/20 through 2/29/20, showed: -An undated order for passive range of motion for the upper and lower extremities, three times a week; -Further review of the record, showed staff documented the resident received the program six out of 12 possible days. 5. Review of Resident #60's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Total dependence of two (+) persons required for bed mobility and transfers; -Total dependence of one person required for dressing, eating, toileting, personal hygiene and bathing; -[DIAGNOSES REDACTED]. Review of the resident's RT treatment record, dated 2/1/20 through 2/29/20, showed: -An undated order for restorative nursing, three times a week; -Further review of the record, showed staff documented the resident received the program seven out of 12 possible days. 6. Review of Resident #92's quarterly MDS, dated [DATE], showed: -admission date of [DATE]; -Extensive assistance of two (+) persons required for bed mobility; -Total dependence of two (+) persons required for transfers; -Total dependence of one person required for dressing, toilet use, personal hygiene and bathing; -Supervision required for eating; -[DIAGNOSES REDACTED]. Review of the resident's RT treatment record, dated 2/1/20 through 2/29/20, showed: -An order dated 12/10/19, for range of motion three times a week; -Further review of the record, showed staff documented the resident received the program eight out of 12 possible days. 7. During an interview on 3/5/20 at 1:53 P.M., the Director of Nursing said until this week, the facility had two RT staff, but one quit this week. The RTs are pulled to work the floor when there are call-ins. When that happens, the residents do not receive their RT programs. MO 551
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on interview and record review, the facility failed to provide evidence that the facility had held at least one Quality Assessment Assurance (QAA) meeting during each of the last four quarters as required. The census was 97. During the entrance interview on [DATE] at 8:30 A.M., the survey team requested proof the facility had held at least one QAA meeting (a committee meeting that includes the Medical Director, key facility personnel and sometimes ancillary personnel such as a representative from the laboratory, pharmacy and skilled therapy to identify and address facility issues) each quarter for the last four quarters. During an interview on 3/3/20 at 1:28 P.M., the administrator said she could only find proof of three of the last four QAA meetings: 6/28/19, 8/13/19 and 1/30/20. She was not the Administrator prior to January 2020. She cannot find proof the facility held a QAA meeting for October/November/December of 2019.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed their policy and provided incontinence care using acceptable nursing practice regarding infection control for two of three residents observed receiving incontinence care. (Residents #2 and #36). The census was 97. 1. Review of Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/11/20, showed: -Limited dependence of one person required for bed mobility; -Total dependence of two (+) persons required for transfers; -Total dependence of one person required for dressing, personal hygiene and bathing; -Always incontinent of bowel and bladder; -[DIAGNOSES REDACTED]. Observation on 3/3/20 at 5:10 A.M., showed the resident lay in bed. Certified Nurse Aide (CNA) F entered the room and without washing his/her hands, donned a pair of gloves, draped a towel half in and half out of the sink, turned on the water and applied soap on top of the towel. As the water ran, the CNA removed the resident's wet brief, then returned to the sink and wrung out the wet portion of the towel. He/she washed the resident's genitalia with the wet portion of the towel, then dried the resident with the dry portion of the towel. He/she removed his/her gloves, donned an new pair of gloves then placed a new towel half in and half out of the sink and repeated the same steps as the first towel. He/she used the second towel to wash and dry the resident's buttocks. After washing the resident's buttocks but before removing his/her gloves, the CNA applied the resident's clean incontinence brief and touched the resident's sheet/blanket. After removing the gloves, the CNA said after washing the resident's buttocks, his/her gloves were dirty and he/she should not have touched the clean incontinence brief or the blanket/sheet. He/she had not thought about the sink being dirty and said he/she should not have laid the towel in the sink. 2. Review of Resident #36's quarterly MDS, dated [DATE], showed: -Persistent vegetative state/no discernible consciousness; -Total dependence of two (+) persons required for bed mobility; -Total dependence of one person required for dressing, personal hygiene, and bathing; -Indwelling urinary catheter (a tube is inserted through the urethra into the bladder to drain urine from the bladder. The urine drains via the catheter into a

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) drainage bag.); -[DIAGNOSES REDACTED]. Observation on 3/3/20 at 6:30 A.M., showed the resident lay in bed on his/her back. CNA C laid a towel half in and half out of the sink, turned on the water and added soap on top of the towel. He/she then used the towel to wash the resident's genitalia. The CNA repeated the same steps with a second towel to wash the resident's buttocks. 3. During an interview on 3/5/20 at 1:53 P.M., the Director of Nursing said she expects staff to follow the facility policy for infection control. The sink is considered dirty. Towels and wash cloths should not be laid in the sink and used to clean a resident. Staff should use bath basins to place warm soapy water, towels and washcloths in. Gloves are considered dirty after washing the buttocks. They should be removed before touching anything considered clean. 4. Review of the facility Perineal Care policy, revised 2/2018, showed: Purpose: -The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition; Equipment and Supplies: -Wash basin, towels, wash cloth, soap, personal protection equipment (gowns, gloves, mask, etc.as needed); Steps in the Procedure: -Place equipment on the bedside stand; -Wash and dry hands thoroughly; -Fill the wash basin one-half full of warm water; -Put on gloves; -Wash an rinse the rectal area thoroughly; -Discard disposable items; -Remove gloves and discard into designated containers; -Wash and dry hands thoroughly.
F 0909 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a routine maintenance program for the inspection and compatibility of bed frames, mattresses and side rails for five of five sampled residents using side (bed) rails. During the survey, (Resident #14) was observed with his/her left shoulder and left arm entrapped between the side rail and mattress. In addition, four other sampled residents observed in bed with side rails in use had no initial or on-going inspections completed of their side rails. The facility identified seven residents that used side rails, five were sampled and problems were found with all five (Residents #14, #93, #17, #61 and 18). The census was 97. Review of the facility's Restraints-Side Rails policy, revised on 6/2019, showed the following: Purpose: The purposes of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms; -Definition: Physical restraints are defined by the Centers for Medicare and Medicaid Services (C[CONDITION]) as any manual method or physical or mechanical device, material, or equipment attached of adjacent to the resident's body that the individual cannot remove easily which restrict freedom of movement or normal access to one's body. (Note: The definition of restraints is based on the functional status of the resident and not the device, therefore any device that has the effect on the resident of restricting freedom of movement or normal access to one's body could be considered a restraint.); -General Guidelines: 1. Side rails are considered a restraint when they are used to limit the resident's freedom of movement (prevent the resident from leaving his/her bed.) (Note: The side rails may have the effect of restraining one individual and not the other, depending on the individual resident's condition and circumstances.) 2. Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. 3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet; c. Risk of entrapment from the use of side rails; and d. That the bed's dimensions are appropriate for the resident's size and weight. 4. The use of side rails as an assistive device will be addressed in the resident's care plan. 5. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. 6. Less restrictive interventions that will be incorporated in care planning include: a. Providing restorative care to enhance abilities to stand safely and to walk; b. Providing a trapeze to increase bed mobility; c. Equipping the resident with a device that monitors attempts to arise; e. Providing staff monitoring at night with periodic assisted toileting for residents who can comprehend this information. 7. Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails. 8. The risks and benefits of side rails will be considered for each resident. 9. Consent for side rails will be obtained from the resident or legal representative, after presenting potential benefits and risks. (Note: Federal regulations do not require written consent for using restraints. Signed consent forms do not relieve the facility from meeting the requirements for restraint use, including proper assessment and care planing. While the resident or family (representative) may request a restraint, the facility is responsible for evaluating the appropriateness of that request.) 10. Manufacturer instructions for the operation of side rails will be adhered to. 11. The resident will be checked periodically for safety relative to side rail use. 12. If the side rail use is associated with symptoms of distress, such as screaming or agitation, the resident's needs and use of side rails will be reassessed. 13. When side rail usage is appropriate, the facility will access the space between the mattress and side rail to reduce the risk of entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used). 14. Side rails with padding may be used to prevent resident injury in situations of uncontrollable movement disorders, but are still restraints if they meet the definition of a restraint. 15. Facility staff, in conjunction with the Attending Physician, will assess and document the resident's risk for injury due to neurological disorders or other medical conditions. 1. Review of Resident #14's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by the facility staff, dated 11/2[DATE]9, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated 11/2[DATE]9, showed: -Problem: Risk for falls related to (r/t) daily use of [MEDICAL CONDITION] drug use, increased anxiety and restlessness. Resident had a fall from his/her bed, no injury r/t frequent movement; - Approach: Check range of motion (Specify #) times daily. For no apparent acute injury, determine and address causative factors of the fall. Monitor/document /report as needed (PRN) x 72 hours to physician for signs and symptoms of pain, bruises and changes in mental status. New onset: confusion, sleepiness, inability to maintain posture, agitation. - Place my side rails up X 2 for safety. Review of the resident physician's orders [REDACTED]. Review of the resident's medical record, showed no side rail assessment was completed. Observation on [DATE], showed: -7:16 A.M.: During the initial tour of the facility, this surveyor could hear the resident calling out loudly mom, mom from the centralized nurse's station. The resident's room was the first room on the right, visible from the nurse's desk. The resident called out repeatedly mom, mom. His/her voice was high pitched, loud and urgent. The resident was partially behind the privacy curtain but visible from the hallway. The resident lay in his/her bed, on a bare mattress, with the head of the bed slightly raised, moving his/her legs back and forth. Both half side rails were up. His/her head was raised at an awkward angle, with his/her left shoulder and arm wedged between the mattress and half side rail on the left side. He/she repeatedly called out mom, mom in a urgent loud voice. The three unidentified nurses were at the nurse's desk. No one from the nurse's desk checked on the resident; -7:20 A.M., showed three nursing staff, including Nurse E, stood or sat at the 100/200/300 nurse's station. A loud voice saying something repetitively could be heard coming from the 300 hall. When asked who was making that noise. Nurse A said that's Resident #14. He/she is saying mom. He/she does that all the time; -7:21 A.M.: showed two unidentified CNAs passed the resident's room. Neither staff member looked in the room. The resident continued to call out repeatedly mom, mom in a loud high pitched voice. The resident remained with his/her left arm/shoulder wedged between the mattress and left side rail; -7:23 A.M.: One unidentified CNA passed room, looked in room, twice, but did not go in. The resident continued to yell out mom, mom in a loud high pitched voice; -7:26 A.M.: a nurse passed the resident's room on his/her way to the nurse's station. Walked back, looked in the room, went in and straightened the resident onto the center of the mattress. He/she lay on a bare mattress, without a sheet, moving his/her legs up and down. The side rails were raised on both sides. He/she continued to call out mom, mom but it was no longer high pitched; -8:30 A.M.: The resident was slumped over to the left of the bed, leaning against the side rail. 2. Review of Resident #93's physician's orders [REDACTED]. Review of the resident's care plan, updated on 2/3/20, showed no information regarding the use of side rails. Review of the resident's significant change MDS, dated [DATE], showed: -Rarely understood; -Required limited assistance of one staff for bed mobility; -Required extensive assistance of two staff for transfers; -Bed rails not used. Further review of the resident's electronic and paper medical record, showed no side rail assessment. Review of the resident's POS, dated March, 2020, showed an order, dated 3/4/20 for

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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 0909 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 12) side rails per family request to aid in bed mobility and repositioning. Observations on [DATE] at 7:14 A.M., 3/2/20 at 6:50 A.M. and 3/4/20 at 6:57 A.M., showed the resident lay in a low bed. Quarter side rails were raised in a horizontal position on both sides of the bed. 3. Review of Resident #17's admission MDS, dated [DATE], showed: -Rarely understood; -Required total dependence of two staff for bed mobility and transfers; -Bed rails not used. Review of the resident's POS, dated February 2020, showed: -[DIAGNOSES REDACTED]. Review of the resident's care plan, updated on 2/19/20, showed no information regarding the use of side rails. Further review of the resident's electronic and paper medical record, showed no side rail assessment. Observations on [DATE] at 7:14 A.M., 3/2/20 at 6:54 A.M., 3/3/20 at 6:55 A.M., and 3/4/20 at 6:59 A.M., showed the resident lay in bed. One half side rail was raised in a horizontal position on both sides of the bed. Review of the resident's POS, dated March 2020, showed an order, dated 3/4/20 to discontinue the use of side rails due to non-use in mobility and positioning. 4. Review of Resident #61's significant change MDS, dated [DATE], showed: -Rarely understood; -Required limited assistance of one staff for bed mobility and transfers; -Bed rails not used. Review of the resident's POS, dated February 2020, showed: -[DIAGNOSES REDACTED]. Review of the resident's undated care plan, showed no information regarding the use of side rails. Further review of the resident's electronic and paper medical record, showed no side rail assessment. Observations on [DATE] at 7:14 A.M., 3/2/20 at 6:55 A.M., 3/3/20 at 6:56 A.M. and 3/4/20 at 7:00 A.M., showed the resident lay in bed. Quarter side rails were raised in a horizontal position on both sides of the bed. 5. Review of Resident #18's quarterly MDS, dated [DATE], showed: -Limited assistance of one person required for bed mobility; -Total dependence of two (+) persons required for transfers; -[DIAGNOSES REDACTED]. Review of the resident's POS, dated [DATE] through 3/3/20, showed no order for side rails. Observation on 3/2/20 at 6:12 A.M., showed the resident lay in bed with two quarter length side rails up, one on each side at the head of the bed. Observation on 3/4/20 at 8:23 A.M. and at 11:22 A.M., showed the resident lay in bed with two quarter length side rails up, one on each side at the head of the bed. Review of the resident's POS, dated [DATE] through 3/31/20, showed a hand written order dated 3/4/20, for the resident to use side rails to aid in bed mobility and repositioning. Review of the resident's medical record, showed no bed rail assessment for the resident's use of side rails. 6. During an interview on 3/4/20 at 9:56 A.M., the maintenance director said he was responsible to follow the facility policies and for the maintenance program to inspect resident beds, including the side rails. He started working for the facility about a month ago. The facility he worked at before beginning here had a maintenance program in place to assess resident beds. As far as he was aware, this facility did not have a maintenance program prior to him starting at the facility. He had been planning to begin a maintenance program, but had not had the opportunity to begin one yet. 7. During an interview on 3/13/20 at 10:43 A.M., the Director of Nurses (DON) said they were doing side rail assessments but when the facility changed the electronic charting from one company to another in September of 2019, and the side rail assessments weren't being completed due to a problem with the system. She was unaware they still weren't being completed until now. She is aware the facility should assess side rails for safety which includes measuring the gaps between the mattress and the side rail and ensure the side rails are in good repair. The prior Maintenance Director was assessing the side rails for safety. He took the documentation regarding the assessments with him. 8. During an interview on 3/4/20 at 12:55 P.M., the administrator said the gap between the mattress and the side rails should have been measured and assessed, prior to the installation of side rails.