| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **045438** | A. BUILDING _____ B. WING _____ | **08/17/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **TRINITY VILLAGE MEDICAL CENTER** | **6400 TRINITY DRIVE PINE BLUFF, AR 71603** |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0641<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure each resident receives an accurate assessment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 219) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure the Minimum Data Set assessments (MDS) accurately reflected antipsychotic use for 1 (Resident #3) of 1 sampled resident who had physician's orders [REDACTED]. Resident #3 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/13/19 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status, received antipsychotic medications 7 out of the last 7 days, and did not receive antipsychotic medications since admission. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/15/20 documented the resident received antipsychotic medications 7 out of the last 7 days and did not receive antipsychotic medications since admission. a. A physician's orders [REDACTED].Quetiapine [MEDICATION NAME] 100 mg (milligrams) TID (three times a day) for [MEDICAL CONDITION] Disorder . A physician's orders [REDACTED]. A physician's orders [REDACTED].[MEDICATION NAME] 0.5 mg (milligrams) BID (twice a day) for [MEDICAL CONDITION] Disorder . b. As of 8/12/2020 at 8:30 a.m., the Care Plan contained no documentation related to Antipsychotic use, side effects, or behaviors. c. On 8/12/2020 at 8:31 a.m., the Licensed Practical Nurse (LPN) MDS Coordinator was asked to review the answer on the MDS regarding Antipsychotic use for Resident #3. She identified the resident had received the medication for 7 days. She was asked to review the question, Did the resident receive Antipsychotic medications since admission which was answered as No. She was asked, Does that make sense? She stated, Oh, no! It doesn't make any sense at all. I answered it wrong. I don't know how I could have done such a thing. |
| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 795) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure a planned fall prevention intervention was consistently implemented and a resident who was at risk for falls was not left unattended after being assisted to a sitting position in a wheelchair on the side of the bed, to prevent potential falls for 1 (Resident #1) who had a history of [REDACTED].#1 who had a fall which resulted in injury, and had the potential to affect 2 residents who were Care Planned to not remain in their room when up, and 60 residents who were assessed to be at risk for falls, according to the lists provided by the Director of Nursing on 8/12/2020 at 1:13 p.m. The findings are: : 1. Resident #1 had [DIAGNOSES REDACTED]. A Significant Change of Status Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/16/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; was totally dependent with two-person assistance with transfers and toilet use; required extensive two person assistance with bed mobility; had functional limitation in range of motion on one side of the upper and of the lower extremities; had one fall with no injury since admission or prior assessment; and had one fall with injury since admission or prior assessment. a. A facility Fall Screen dated 3/20/2020 documented, .Location of fall . Resident's room . Intervention . Resident to be placed in common area when no one is available to be in her room . (signed by Licensed Practical Nurse (LPN) #6 on 3/4/2020) . b. A facility Incident and Accident Report dated 5/20/2020 documented a fall with injury at 6:54 a.m. and documented, .(Resident #1) was wheeling out of her room and yelled, 'Help, this lady is falling on the floor out of the wheelchair'. I called for assistance. I arrived down there. Resident #1 was lying on the floor on her right side with head bleeding. No other bruises or injuries noted at the time of assessment. AROM (active range of motion) to all extremities with no facial grimaces. Her legs were caught into the wheelchair. I assisted with moving wheelchair so (name) could apply pressure to right side of head while I make all the phone calls and get paperwork ready. Family, DON (Director of Nursing), and Doctor contacted. Resident was sent to ER (emergency room ) . The Nurse's Notes from 5/20/2020 at 3:00 a.m. through 5/21/2020 at 7:00 p.m. documented respiratory assessments, pain assessments, and antibiotic use. The Nurses Notes contained no documentation related to the fall or neurological assessments. c. A Hospital Discharge Instruction Sheet dated 5/20/2020 provided by Licensed Practical Nurse (LPN) #1 documented discharge instructions as, .Sutures out in a week, monitor sugar, and fall precautions . LPN #1 was asked for further discharge information and / or orders. LPN #1 was asked if there were no papers as to how many sutures were required to close the wound? She stated, No ma'am. That's all we have. d. On 6/3/2020 at 2:03 p.m., Certified Nursing Assistant (CNA) #2 was asked, How long have you worked at the facility? She stated, Six weeks. She was asked, Tell me about (Resident #1's) fall on 5/20/2020. She stated, I was told that (Resident #1) was in her chair and that (Name) was being paid by the family to feed her. I was assigned to her that day. I kept making sure (Resident #1) was okay, and in her chair properly and couldn't fall. This was the first time I took care of her. I was handing out trays and cutting food up for residents. Someone asked for something different on their tray, so I went to the kitchen to put that order in and when I came back, I heard that she had fell . So, I immediately went to see what was going on and see how bad she was injured and if she was responsive. They told me not to touch her until they assessed. I got down on the floor next to her to calm her down and got her to focus on me until the ambulance got there. They got towels. She had got tangled up in her wheelchair. We kept compression on her head until the ambulance got here. I was checking on her in between when the ambulance got here. I have never had that happen to me before. Most of the time she is in her bed. But this time she was in a room by herself in quarantine. She normally shared a room with someone else. (Resident #1) has never wobbled in her chair before. I don't know what happened. She was asked, Were you aware she was a fall risk before that fall happened? She stated, Yes, ma'am. She was asked, How did you know that? She stated, I remember training on this floor and was told she was. And that when she is in her chair, she had to be set back some. And she was like that when she fell . The chair was reclined a little bit. She was asked, So, it was a high-back wheelchair that would recline? She stated, I believe so. She was asked, Were you aware she was not supposed to be left alone in her room in a chair? She stated, I have never heard that. I was not aware of that. She was asked, Where do you go to see information like residents who are at risk for falls, and how much transfer assistance is needed? She stated, I know that on our Assignment Paper for who we have for the shift will have stuff written on it. I think the Nurse fills that out. If there's a book I can go to, I've never seen one. I was just told to make sure she was okay in her chair and to keep checking on her. e. On 6/3/2020 at 2:30 p.m., the (Former) Director of Nursing (DON) was asked, (Resident #1's) Care Plan documented after the 3/2/2020 fall as an intervention for staff to put her at the Nurse's Station in the evening until time to put her in bed. Why was she in her room by herself when she fell on [DATE]? She stated, Because of the COVID isolation. She had just come back from the hospital on [DATE] and we have to put residents in isolation by themselves for 14 days. And she doesn't try to get out of the bed. She tries to get out of her chair. She didn't fall out of bed on 5/20/2020. She fell out of her chair. She was asked, What was the intervention to prevent recurrences after the 5/20/2020 fall? She stated, I told staff after the fall to not leave her in |

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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| | 045438 | A. BUILDING _____ B. WING _____ | 08/17/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| TRINITY VILLAGE MEDICAL CENTER | 6400 TRINITY DRIVE PINE BLUFF, AR 71603 |

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>there by herself. She was asked, Because of the COVID, and her having to be in isolation after returning from the hospital, what was the intervention to prevent falls for her since she had a history of [REDACTED].? She stated, Rounding and checking on her. She had not been in her chair until that day. She had just returned from the hospital and we felt she was not strong enough on that day for her to get in her chair. f. On 6/3/2020 at 3:10 p.m., Licensed Practical Nurse (LPN) #1 was asked about the resident's fall. She stated, She was on my hall. I was still orientating. (LPN #3) was the nurse. She (the resident) was up and in the wheelchair in her room. When we did our Med (Medication) Pass, she was still up and in the chair. We completed the Med Pass around 5:00 p.m. to 6:00 p.m. We were sitting having lunch. (LPN #3) came and said, 'I need you now. (Resident #1) is in the floor'. So, I jumped up and she was in the floor and there was blood in the floor. I applied pressure like I was told and when the Emergency Medical Technicians (EMTs) got here, they took her to the hospital. My supervisor was (Registered Nurse (RN) #2) and she told me to put pressure on her head. She's an RN. She was asked, 'Were you aware she was a fall risk prior to this fall? She stated, I didn't know. She was asked, Had you taken care of her before? She stated, Yes, but I didn't know she was a fall risk. She was asked, How do they let you know someone is a fall risk? she stated, I don't know, but I will find out and let you know. But I know her daughter left a note in her room on a board that she is to be up at all meals. She was asked, Did you know she wasn't supposed to be up in her room by herself? She stated, No, ma'am. This was my first time to know of her falling. g. On 6/3/2020 at 3:30 p.m., RN #3 was asked, Talk to me about a fall on 5/20/2020. She stated, I didn't work with her that day. I was working at another station but then counted out and went to her hall, but she had already gone to the hospital. I heard about her fall, but I was working the other end of the building. She was asked, Had you ever provided care to her before then? She stated, I had taken care of her before. (Resident #1) is non-verbal. She used to be alert oriented times 3 (person, place and time), could walk, but then had a bad stroke. Now she is dependent. She has to be fed, wears a brief (incontinent brief). She was asked, Did she have a habit of trying to get out of her chair? She stated, Sometimes. She's unaware of what she's doing. She has a tendency to reach down or bend over. She was asked, Has she ever fallen doing that before? She stated, I can't honestly recall because when I did work on the floor all the time, I didn't work on that hall. She was asked, Was she a fall risk before she fell on [DATE]? She stated, Yes. She was asked, Were you aware that if she was up in her chair, she was to be at the Nurse's Station for supervision? She stated, Yes, I was aware of that. h. On 6/3/2020 at 3:47 p.m., CNA #1 was asked, Did you have anything to do with taking care of (Resident #1) when she fell on [DATE]? She stated, She was not my resident. I was working that hall, but I was at the other end. It was around supper time and we were passing out our trays, then we went to feed our residents. I was in a room feeding, and after I got through, I started checking on other residents and I heard that she fell . I went down there to see what happened. There was a lot of blood on the floor, so I asked if there was anything I could do to help, so I went and grabbed towels. Then we tried to get (RN #2) on the intercom. She didn't come as soon as we called, so I went and got her, and she came to see about her. And then the EMTs (Emergency Medical Technicians) came and got her. She was asked, Had you ever taken care of her before? She stated, Yes, I had. When we were passing out trays she was sitting up in her wheelchair in her room. And she had just got back from the hospital earlier that week because she was dehydrated. But yes, I had taken care of her before that happened. She was asked, Were you aware she was a Fall Risk before this last fall? She stated, All I knew, well mostly she stays in bed. Nobody has been getting her up. I mean, I guess. I know she can't stand up on her own. She can't walk. She was asked, How do you find out if someone is a Fall Risk? She stated, Nobody has ever told me she was a Fall Risk. She was asked, Is there a book that would tell you? She stated, They would have it in the record, but I'm sure there is a book that has that, but I've never seen that since I've been here. And when I was being trained, they never said anything about there being a book that says that. She was asked, Is it important to make staff aware if someone is a Fall Risk? She stated, Yes. She was asked, She had a history of [REDACTED]. Did you know that? She stated, No, ma'am. i. On 6/3/2020 at 6:21 p.m., CNA #3 was asked how long she had been employed at the facility. She stated, Two months. She was asked, Tell me about the fall (Resident #1) had on 5/20/2020? She stated, I was on the other end of the hall. I remember hearing that she fell , and she was going to the hospital and when she came back, she was bruised up. One CNA was saying they wanted to take her out of the chair, but someone else said she was supposed to get therapy and that's why they wanted her to stay up. There was a reason for her to still be in the chair, but I don't remember. She was asked, Had you ever taken care of her before? She stated, Yes, when she was on the other end, I had changed her and given her food. She was asked, Had you ever seen her try to get out of her chair before? She stated, No, usually when I come, she be in bed. She was asked, Were you aware she was a Fall Risk before the 5/20/2020 fall? She stated, No, ma'am. She was asked, Where do you find out that type of information? She stated, Other CNAs or a nurse. Sometimes there's signs in the room. There's a book I think at the Nurse's Station. I don't know if it has that kind of information in it. She was asked, What do you do for a resident who is a Fall Risk and they're in the room by themselves? She stated, We have had ladies by the Nurse's Station because they are Fall Risk. j. On 6/4/2020 at 10:00 a.m., LPN #2, MDS / Care Plan Coordinator was asked, How long have you worked here? She stated, Five years. She was asked, Where are the fall interventions documented? She stated, They are listed on the Care Plan. She was asked, I see on (Resident #1's) Care Plan that she fell on [DATE], but I do not see any interventions listed to prevent recurrences after that fall. She stated, I don't see any either. I don't know how it was missed. She really needs two people helping her, but she won't allow it. So, we all do the best we can. I don't know why I don't have an intervention. k. On 6/4/2020 at 12:40 p.m., LPN #3 was asked how long she had worked at the facility? She stated, Almost nine years. She was asked, Were you on duty when (Resident #1) fell on [DATE]? She stated, Yes, I was here when she fell this last time. I was on the hall and a resident said that this lady just fell . I yelled for help, ran down there, and she had fallen out of her chair and hit her head. (CNA #5) was training with me and (RN #2) was there. We all went down there. I called the ER (emergency room ) and the doctor. Everything I was supposed to do once we got the bleeding covered up. The RN Supervisor stayed down there the whole time. She was asked, Did she have a habit of trying to get out of her chair at times? She stated, Usually when she is in her chair, she is sitting back. She had just returned from the hospital and they placed her down there. She will lean forward at times, but not like lean down to try to pick up things to the point that she would fall out. She was asked, What fall intervention was being implemented at that time since she was in quarantine? She stated, When I came in, they had her back, the chair wasn't sitting straight up. It was kind of leaning back. I am not her normal nurse. With her being under quarantine, she was on a different hall. She was asked, Was she in a high-back wheelchair? She stated, Yes. She was asked, Was she weak? She stated, Not that I know of. The nurse said the family wanted her to stay up and eat the 5:00 p.m. meal in her wheelchair because they had one of the workers coming in and feeding her. Her normal nurse is (LPN #3). She works on B Hall every day. She was asked, What interventions have been implemented since that last fall? She stated, They haven't told me what fall interventions have been put into place since that last fall. l. On 6/4/2020 at 1:05 p.m., Social Service Director stated she had been employed at the facility for [AGE] years and had been the Social Service Director for the last [AGE] years. She was asked, Does (Resident #1) sometimes lean forward in her chair? She stated, Yes. She sits up sometimes in the lobby. A lot of times she pulls herself forward trying to pull her brace off or shoe off. I put that in my note because a lot of times we have to get her to lean back and situated. A lot of times I take her outside to try and get her to relax. Before this pandemic she sat at the Nurse's Station to be watched. She was asked, What is being done for residents now that they can't be at the Nurse's Station anymore? She stated, I make a lot of room visits. We have some now that we take out of their rooms and keep them far apart, so they won't be in their rooms all the time. Before (Resident #1) was hospitalized , we were taking her outside. m. On 6/4/2020 at 1:14 p.m., LPN #5, Staff Educator, stated she had been employed at the facility for four years. She was asked, Do you work the floor at times? She stated, Yes. She was asked, Have you worked with (Resident #1)? She stated, I have when I worked up here a couple of nights in the evening time passing medications. She was asked, Tell me about her. She stated, I know she's had [MEDICAL CONDITION], right sided weakness, totally dependent, lift to get in / out of the bed. When she's up in a wheelchair, we always brought her to the Nurse's Station to monitor her. Always made sure the side rails were up and that she was comfortable. She's a total care and we have to help her eat. She was asked, Why was she at the Nurse's Station for monitoring? She stated, Because she likes to bend down and pick things up. Her right foot has a boot and she will mess with the Velcro. She has taken her shoes off. She does like to lean over, so we put her at the Nurse's Station to monitor her. We would watch her to adjust her and make sure she is sitting up in the wheelchair. She was asked, What did the facility do to prevent her from falling once she was in quarantine? She stated, I normally only work in the evening time so she was always in the bed. I know they normally let her lay in the bed and turn her every two hours and monitor her through the shift to make sure she is comfortable. She was asked, Is being in the wheelchair by herself appropriate for her? She stated, I can't answer for the other nurses, but in my opinion, I wouldn't have had her up in the chair like that. I have taken care of her since she's been in here. I am |

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>aware of and know her. The other nurses, I can't answer for them. I know her personally and how she does and as far as her leaning goes. She is confused and most of the time when she is up, she is pulling and leaning and doesn't know what is going on. n. On 6/4/2020 at 1:33 p.m., LPN #4 stated she had been at facility for almost three years and worked B Hall. She was asked, Do you normally take care of (Resident #1)? She stated, Yes. I have been on this hall since January (2020). She is non-verbal, she requires a lift. Before she was on isolation, they would get her up in the mornings with the lift. She did not eat really well. Once the COVID started and we had to start feeding her in the room, it went down a little. There is one CNA (#4) that she responds really well to and she does better with her. Most of the time they get that CNA . She was asked, Did staff used to monitor her at the Nurse's Station? She stated, Yes, we would. She was asked, Why? She stated, She would, we were worried she would fall out of it if someone wasn't watching her at all time. The CNAs would do their 2-hour checks. But like with this last fall, the nurse would go in to check on her, but then left and it happened. She was asked, Did she have a habit of leaning while in her chair? She stated, Yes. I have had to get help to reposition her a few times. She has the high-back wheelchair. She was asked, So, if she couldn't be at the Nurse's Station for monitoring, what fall interventions were implemented due to her being in quarantine? She stated, Me, as a nurse for [AGE] years, I would have gotten with the aides to make sure she was checked on frequently. And she was in the bed more. She was asked, Do you feel it was a good idea to leave her in her room unattended? She stated, No. o. The facility Fall Prevention Program provided by the Director of Nursing on 8/12/2020 documented, .Ensure that staff are educated to the definition of a fall, complete a Fall Risk Assessment . When a fall occurs the DON / Designee will review the I&A (Incident and Accident Report), review Post Fall Investigation and evaluate for trends . Update Care Plan . Identify residents who qualify for placement in the 'Falling Star Program' . |
| F 0690<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure urinary catheter tubing and urinary drainage bags were kept off the floor for 1 (Resident #4) of 1 case mix resident who had an indwelling urinary catheter to prevent potential cross-contamination and infection. This failed practice had the potential to affect 1 Resident who had an indwelling urinary catheter, according to the list provided by the Director of Nursing (DON) on 8/12/2020 at 1:22 p.m. The findings are: 1. Resident # 4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference<br>Date of 7/19/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status, required extensive assistance with bed mobility, transfer, toilet use, and bathing, and had an indwelling urinary catheter. a. The Care Plan dated 10/17/19 documented, .Catheter . Check drainage tubing for kinks or blockages . Monitor intake and output as ordered . Observe for signs and symptoms of infection; change in character of urine .Provide catheter care as needed . Catheter Care . Urinary . Infection Control . 2.b. Be sure the catheter tubing and drainage bag are kept off the floor . b. The Physician's Listing dated August 2020 documented, .Supra Pub (suprapubic catheter) changed monthly on Tuesday . c. On 8/10/2020 at 10:33 a.m., Resident 4 was sitting in a wheelchair in front of the biohazard room, which was located on the Station 1, A Hall. The resident's indwelling urinary catheter tubing and urinary drainage bag were touching the floor. (The Surveyor took a photograph of the catheter tubing and drainage bag at this time.) |
| F 0695<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure nebulizer masks and nasal cannula tubing were stored in a bag or covered container when not in use to prevent potential cross-contamination for 2 (Residents #6 and #7) of 2 case mix residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 12 residents who had physician's orders [REDACTED]. Resident #6 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 5/27/2020 documented the resident was severely impaired in cognitive skills for daily<br>decision making per a Staff Assessment for Mental Status (SAMS); required extensive assistance with bed mobility, transfers, dressing, eating, and personal hygiene; was always incontinent of bowel and of bladder; had no shortness of breath; and did not require oxygen therapy. a. The physician's orders [REDACTED].[MEDICATION NAME] BID (twice daily) 0800 (8:00 a.m.), 1600 (4:00 p.m.) 1 Vial / inhalation by nebulizer 2 times a day for [MEDICAL CONDITIONS] .[MEDICATION NAME]-[MEDICATION NAME] 0.5-2.5 (3) MG (milligrams) (per) 3 ML (milliliters) PRN (as needed) every 4 hours as needed for shortness of breath . The physician's orders [REDACTED].O2 (oxygen) order . O2 at 2 L/M (Litters Per Minute) via NC (Nasal Cannula) to maintain SPO2 (Peripheral Oxygen Saturation) (at) 93% or greater . b. On 8/10/2020 at 10:50 a.m., the resident was lying in bed. A nebulizer mask and tubing were lying on a bedside table and were not stored in a bag or closed container. The resident's oxygen tubing with nasal cannula was wrapped around the oxygen flow meter of the oxygen concentrator and was not in a bag or closed container. c. On 8/10/2020 at 2:27 p.m., the resident was lying in bed. A nebulizer mask and tubing were lying on a bedside table and were not stored in a bag or closed container. The resident's oxygen tubing was wrapped around the oxygen flow meter of the oxygen concentrator and was not in a bag or closed container. d. On 8/11/2020 at 9:01 a.m., the resident was lying in bed. A nebulizer mask and tubing were lying on a bedside table and were not stored in a bag or closed container. The resident's oxygen tubing was wrapped around the oxygen flow meter of the oxygen concentrator and was not in a bag or closed container. Registered Nurse (RN) #1 was asked, Does the resident use the oxygen? She stated, It's PRN (as needed). She was asked, Is the oxygen mask and tubing supposed to be sitting on the table and not contained? She stated, No, it's not. She was asked, Is the oxygen tubing and cannula supposed to be wrapped around the flow meter and not contained? She stated, No, it's not. e. A facility policy titled Oxygen Administration provided by the Administrator on 8/12/2020 at 9:21 a.m. documented, .Infection Control . 3. Place mask, nasal cannula, nasal catheter, or mouthpiece in a plastic zip lock bag when not in use . 2. Resident #7 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/9/2020 documented the resident scored 3 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, transfers, dressing, and personal hygiene; did not have shortness of breath; and did not require oxygen therapy. a. The physician's orders [REDACTED].[MEDICATION NAME] 0.5-2.5 (3) MG (milligrams) (per) 3 ML (milliliters) PRN (s needed) for Shortness of breath . The physician's orders [REDACTED].O2 (oxygen) at 2 LPM (liters per minute) PRN (as needed) via N/C (nasal cannula) . b. The Care Plan with a revised date of 7/31/2020 documented, .Monitor O2 (oxygen) sats (saturations) and administer oxygen as ordered . O2 (oxygen) (at) 2 L/min (liters per minute) via NC (nasal cannula) or mask PRN (as needed) . c. On 8/10/2020 at 10:43 a.m., Resident #7 was lying in bed. The oxygen tubing and nasal cannula were lying on a blue chair in the resident's room and were not stored in a bag or closed container. d. On 8/10/2020 at 2:25 p.m., Resident #7 was lying in bed. The oxygen tubing and nasal cannula were lying on a blue chair in the resident's room and were not stored in a bag or closed container. e. On 8/11/2020 at 9:07 a.m., Resident #7 was lying in bed. The oxygen tubing and nasal cannula were lying on a blue chair in the resident's room and were not stored in a bag or closed container. RN #1 was asked, Does she (the resident) use the oxygen? She stated, It is PRN (as needed). She was asked, Is the oxygen tubing and nasal cannula contained correctly in the chair? She stated, No, ma'am. |
| F 0760<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure that residents are free from significant medication errors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Complaint # (AR 795) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed ensure physician orders [REDACTED].#1 and #9) of 2 (Residents #1 and #9) case mix residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 7 residents who had physician's orders [REDACTED]. Resident #1 had [DIAGNOSES REDACTED]. A Significant Change of Status Minimum Data Set (MDS) with an Assessment<br>Reference Date (ARD) of 6/16/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status and did not received insulin injections. a. A physician's orders [REDACTED].Treatment Frequency MED (medication) . BID (twice daily) .0600 (6:00 a.m.) 1600 (4:00 p.m.) Regular insulin sliding scale . 0-200 = 0 units, 201-250 = 7 units, 251-300 = 9 units, 301-350 = 11 units, 351-400 = 15 units, 401 and over recheck blood sugar and call physician . Recheck blood sugar in 2 hours . If coming down, recheck at 4 hours post administration . b. The Care Plan dated 7/23/2020 documented, .Resident is at risk for complications associated with hyper or hypoglycemic related the DMII (Diabetes Mellitus Type II) Accu Checks per MD (Medical Doctor) order . Administer insulin as ordered . See MAR (Medication Administration Record) . c. The Medication Administration Record [REDACTED]. blood sugar |

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|---|---|---|---|
| | 045438 | A. BUILDING _____ B. WING _____ | 08/17/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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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 0760<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 3)<br>result 302 . amount of insulin administered was 0. The resident should have received 11 units of insulin based on the physician's orders [REDACTED].blood sugar result 203 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 202 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 201 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 225 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 217 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 270 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED]. blood sugar result 217 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. The Medication Administration Record [REDACTED].blood sugar result 221 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 226 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 209 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 220 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 225 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 205 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 227 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result 231 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 210 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 214 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. blood sugar result 206 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 214 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 205 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 291 . amount of insulin administered was blank. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar result 235 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 314 . amount of insulin administered was blank. The resident should have received 11 units of insulin based on the physician's orders [REDACTED].blood sugar result 206 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar result was blank. On 5/14/2020 at 6:00 a.m. . blood sugar result 216 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 340 . amount of insulin administered was blank. The resident should have received 11 units of insulin based on the physician's orders [REDACTED].blood sugar result 205 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 362 . amount of insulin administered was blank. The resident should have received 15 units of insulin based on the physician's orders [REDACTED].blood sugar result 268 . amount of insulin administered was blank. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar result 240 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 241 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar result 270 . amount of insulin administered was blank. The resident should have received 9 units of insulin based on the physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. blood sugar results 212 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 258 . amount of insulin administered was blank. The resident should have received 9 units of insulin based on the physician's orders [REDACTED]. blood sugar results 251 . amount of insulin administered was blank. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar results 332 . amount of insulin administered was 0. The resident should have received 11 units of insulin based on the physician's orders [REDACTED].blood sugar results 201 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 215 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 289 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar results 300 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar results 292 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar results 243 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 233 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 226 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 208 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 223 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 274 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar results 251 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. blood sugar results 234 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 255 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED].blood sugar results 255 . amount of insulin administered was 0. The resident should have received 9 units of insulin based on the physician's orders [REDACTED]. blood sugar results 277 . amount of insulin administered was 0. The resident should have received 9 units based on the physician's orders [REDACTED].blood sugar results 230 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 240 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 211 . amount of insulin administered was 0. The Resident should have received 7 units of insulin based on the physician's orders [REDACTED]. blood sugar results 224 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 238 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED].blood sugar results 223 . amount of insulin administered was blank. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. The Medication Administration Record [REDACTED].blood sugar results 227 . amount of insulin administered was 0. The resident should have received 7 units of insulin based on the physician's orders [REDACTED]. Resident #9 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 7/23/2020 documented the resident<br>scored 11 (8-12 indicates moderate impairment) on a BIMS and received insulin injections 7 out of the last 7 days. a. A physician's orders [REDACTED].Accu Check AC (Before Meals) / HS (Hour of Sleep) BS (Blood Sugar) 61-150 give 0 units, BS 151- 200 give 4 units, BS 201-250 give 6 units, BS 251-300 give 8 units, BS 301-350 give 10 units, BS 351-400 give 12 units, BS 401-451 give 14 units and notify MD (Medical Doctor) if blood glucose (less than) 60 or (greater than) 451 . Give immediately after meals and hold if she does not eat . b. The Medication Administration Record [REDACTED]. The resident should have received 6 units of insulin based on the physician's orders [REDACTED]. On 6/3/2020 at 3:30 p.m., Registered Nurse #3 (RN) was asked, Where do you document accu-check results and how much sliding scale insulin is administered? She stated, I document it in my EMAR (Electronic Medication Administration Record)). It has the order for what type (of insulin), the amount, and if it's SSI (sliding scale insulin) or standard, it will specify. Then a blank for accu-check and |

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| F 0760<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>then a blank for how many units are administered. She was asked, What does it mean if there's a blank on the MAR (Medication Administration Record)? She stated, That means I need to call the doctor because maybe there's not an order. I would need to report it to my DON (Director of Nursing) and make it known to the nurse who does the in-services to remind the nurses to be mindful not to forget to document it because if you don't document it it's like you didn't do it. a. On 6/4/2020 at 12:40 p.m., Licensed Practical Nurse (LPN) #3 was asked, Where do you document the accu-checks and SSI administration? She stated, In our computer. We have to put what the blood sugar is, and we also have to put how much insulin we gave. She was asked, Is there some sort of alert in the system that tells you when something isn't given, like a medication? She stated, It will have a red alert come up. If it's not put in, it will say 'Not Administered'. She was asked, Your initials are here on a day that she (the resident) would have required SSI, but you didn't document that you gave her any? She stated, I'm not sure how I missed that because I normally put down how much insulin I give. She was asked, Will it let you close that out if you don't document it? She stated, It will say 'Med Pass Fully Complete'. It should have flagged it. I'm not sure why it didn't. It usually shows up a red alert. Once I give my insulin, I always put it in there. If I put her accu-check in there, I gave the insulin. b. On 6/4/2020 1:14 p.m., LPN #5 was asked, Where do you document accu-checks and SSI administration? She stated, On our computer on our MAR. It comes up, and when you write the accu-check, and it has the sliding scale in the common area, and it tells you how much to give and you write how much insulin you're giving her. She was asked, Is there some kind of alert in the system that tells a nurse when the medication isn't given? She stated, No. It won't tell you if you're supposed to give insulin and you don't. She was asked, It shows that you didn't give any insulin when the sliding scale says you should have? She stated, I'm not sure why it wouldn't show up. I always put down where I give it. I'm not sure what actually happened then. I always give the insulin. Maybe it's a glitch. She got her insulin. c. On 6/4/2020 at 1:51 p.m., RN #3 was asked, The documentation sent by the DON reflected a few spots where you should have given SSI based on (Resident #1's) accu-check reading, but it is blank? She stated, If I'm not mistaken, she had 2 different orders. For some, where we record the accu check reading, and a space or 2 under that, it will be the order and how much we gave. If I didn't put it there it may be in the other spot. I did see where her accu check order does contain her sliding scale, so we would put it right there with the accu check reading. d. On 6/8/2020 at 3:58 p.m., LPN #7 was asked, I reviewed the accu-checks and sliding scale insulin administration log for (Resident #1). There are 17 different occasions where she should have had insulin given according to the accu-check reading you documented. Do you remember giving her the insulin? She stated, What I'm thinking is when I put in the accu-check, down at the bottom of that sheet it says no sliding scale. Some of them say no sliding scale and I was thinking she was one of them. I have given her sliding scale insulin before, but that was when she was getting blood sugars at night. She doesn't get that at night anymore. She gets that done in the morning on my shift. She was asked, When you give insulin do you document it? She stated, Yes ma'am, but I don't give any sliding scale. All that shows up on my MAR indicated [REDACTED]. The only sliding scale insulin I can think of right this minute is the lady in (room number). e. On 8/10/2020 at 5:02 p.m., the Assistant Director of Nursing (ADON) was asked if anyone had identified prior to the survey concerns over the sliding scale issue? She stated, No one told me. She was asked, Do you use the accu check sliding scale report? She stated, No. She was asked, What does the report tell you? She stated, Gee, it's not being given. She was asked, Should you use the report? She stated, Yes. The DON and ADON were informed of the significant medication errors. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review, and interview, the facility failed to ensure that staff wore face coverings / masks properly to prevent potential spread of COVID-19; and failed to ensure proper personal protective equipment was available for staff use on the COVID-19 unit to prevent the potential spread of COVID-19 and other disease and infection. These failed practices had the potential to affect 65 residents who resided in the facility, as documented on the lists provided by the Director of Nursing (DON) on 8/12/2020 at 1:22 p.m. The findings are. 1. On 8/10/2020 at 9:50 a.m., during the screening process for the surveyors upon entry to the facility, the facility Van Driver came into the facility. The Van driver had a mask on and was pushing a resident in a wheelchair into the facility. The resident did not have a mask on. The Van Driver was asked, Where has she (the resident) been? The Van Driver stated, To [MEDICAL TREATMENT]. The Van Driver was asked, Do you normally bypass the screening station? The Van Driver stated, No, ma'am. The Director of Nursing (DON) directed the Van Driver to come back to the screening station. a. On 8/10/2020 at 10:06 a.m., Floor Technician #1 was between Station 2 and 3. Floor Technician #1 had a mask on the face, but the mask was not covering the nose as he was finishing the floors. b. On 8/10/2020 at 10:22 a.m., Housekeeping Employee #1 was walking down the hall between Station 2 and 3. Housekeeping Employee #1's mask was pulled down below his chin exposing his mouth and nose. He was asked, What are you doing without your mask on? He stated, Trying to catch the sweat. c. On 8/10/2020 at 10:37 a.m., Housekeeping Employee #2 was in room [ROOM NUMBER] cleaning the resident's bathroom. Housekeeping Employee #2's mask was on but was not covering her nose. She was asked, Is your mask supposed to cover the nose? She stated, Yes, ma'am. 2. On 8/14/2020 at 5:15 a.m., Licensed Practical Nurses (LPN) #5 was on the COVID-19 Hall. LPN #5 placed an N-95 mask on as well as a gown. The facility had one COVID-19 Positive resident, Resident #3 in room. The resident in the room across the hall was not positive for COVID-19. Both resident's doors were open to the hallway, and both were lying in bed, Certified Nursing Assistant (CNA) #8 was getting a drink in the break room and did not have a mask on. She walked into the hall and picked up two surgical masks and placed them over her nose and mouth. (The Surveyor took a photograph of the CNA without a mask with her consent) The CNA also had foot covers on. CNA #8 was asked, Do you have an N95 mask to wear while you're working here on the isolation unit? She stated, No, ma'am. I don't have one. I was told to wear one, but they're not out here. They're locked up. She was asked, Did you ask someone for an N95 mask? She stated, No, ma'am. That's why I have two of these masks on. Licensed Practical Nurse (LPN) #5 was asked to open the plastic isolation container drawers to review for N95 masks. She stated, No, ma'am. There aren't any in here. There's supposed to be in the isolation containers. She was asked, Are there gowns (isolation gowns) in the drawers? She stated, Yes, ma'am. CNA #8 was asked, Where's your gown? She stated, I only put it on when I go into the room, then I remove it before I leave the room. LPN #5 was asked, Where are the N95 masks kept? She stated, In the DON's (Director of Nursing's) office. a. On 8/14/2020 at 6:34 a.m., the DON was asked, Should the isolation containers on the COVID-19 Hall contain N95 masks? She stated, Yes, they should be in there. They are only supposed to wear them on that hall, that's why they're locked up. The nurses are to have a supply in their locked supply room. I have the extra supply . b. The facility policy titled COVID-19 provided by the Administrator on 8/14/2020 at 9:40 a.m. documented, .Wear gowns, gloves, N95 masks when in direct contact . |