STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265797	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGE CREST NURSING CENTER	**706 SOUTH MITCHELL WARRENSBURG, MO 64093**

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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a Certified Nursing Assistant (CNA) did not provide care outside their scope of practice for three out seven sampled residents (Residents #102, #100, and #103), when CNA B had performed blood sugar checks and breathing treatments for the residents on the COVID-19 (a new disease caused by a novel (new) coronavirus) unit. The facility census was 41 residents. Record review of the facility CNA job position 2003 Med-PASS, Inc. showed: -CNA position was to provide routine daily nursing care and services in accordance, of the resident's assessment and care plan. -CNA supervisors may direct other resident care services. -Under special care function included; --CNA can provide physical and respiratory therapy as instructed. --Perform special treatments as instructed. -He/She are only to use equipment that, he/she had been trained to use. -No indication to be able to perform blood sugar checks or nebulizer (a device used to administer medication to people in the form of a mist inhaled into the lungs) treatments with physician order [REDACTED]. -Certified and Licensed staff will cover direct care positions. -Did not indicated to work out of scope of practice. 1. Record review of Resident #102's Admission Face Sheet showed he/she was admitted to the facility on [DATE] had a [DIAGNOSES REDACTED]. -[MEDICAL CONDITION] (disorder that impairs the ability of the heart to fill with or pump a sufficient amount of blood throughout the body) -On 6/29/20 new [DIAGNOSES REDACTED]. was cognitively intact. -Was able to express ideas and wants. -Had the ability to understand other, had clear comprehension. -Required insulin injection during look back of 7 days. -Required limited assistance from one staff member for toileting and personal cares. Record review of the resident's physician's orders [REDACTED]. -On 7/10/20 new order for [MEDICATION NAME] (breathing treatment medication) 0.5 milligram/2 milliliters one vial by nebulizer inhalation two times a day for seven days. -Humalog N-100 (fast acting insulin) sliding scale of blood sugar results of 0-150 = 0 units of insulin, 151-200 =2 units, 201-250 =4 units, 251-300 =6 units, 301-350= 8 units and 351-400 =10 units. Nursing staff are to call the resident's physician if blood sugar less than 60 or over 400. Insulin is to be given subcutaneous (SQ, under skin) with meals. Record review of the resident's Treatment Administration Record (TAR) July 2020 showed: -On 7/14/20 at 12:00 P.M., had no documentation for the blood sugar obtained. -On the sliding scale results had random blood sugar of 195 and was give 2 units of Humalog insulin in left deltoid. -Did not show documentation of who completed the blood sugar test. -[MEDICATION NAME] 0.5 milligram/2 milliliters one vial by nebulizer inhalation two times a day for seven days, had no documentation of who administered the breathing treatment on 7/14/20 and had nurse initial on 7/11/20 to 7/13/20 for morning treatment. No documentation for evening treatments. 2. Record review of Resident #100's Admission Face Sheet showed he/she was readmitted to the facility on [DATE] had a [DIAGNOSES REDACTED]. -Sleep apnea (difficulty breathing at night). -On 7/8/20 new [DIAGNOSES REDACTED]. [REDACTED]. -On 7/13/20 new order for [MEDICATION NAME] 0.5 mg/2 ml one vial by nebulizer inhalation two times a day for seven days. -[MEDICATION NAME] N-100 (fast acting insulin) sliding scale of blood sugar results of 0-150 = 0 units of insulin, 151-200 =2 units, 201-250 =4 units, 251-300 =6 units, 301-350= 8 units and 351-400 =10 units. Nursing staff are to call the resident's physician if blood sugar less than 60 or over 400. Insulin is to be given SQ with meals. Record review of the resident's TAR, July 2020, showed: -On 7/14/20 at 11:00 A.M., had documentation of blood sugar of 158, no nursing initial who obtained blood sugar. -On the sliding scale results had random blood sugar of 158 and was give 2 units of [MEDICATION NAME] insulin. -Did not have a nurse initial of who did the blood sugar test. -Ordered date of 7/13/20 [MEDICATION NAME] 0.5 mg/2 ml one vial by nebulizer inhalation two times a day for seven days was given on 7/13/20 and 7/14/20 in the morning no documentation of the night time dose found. 3. Record review of Resident #103's Admission Face Sheet showed he/she was readmitted to the facility on [DATE] had a [DIAGNOSES REDACTED]. -[MEDICAL CONDITION] (an infection of deep skin tissue) -On 7/8/20 new [DIAGNOSES REDACTED]. -Was able to express ideas and wants. -Had the ability to understand other, had clear comprehension. -Required limited assistance from one staff member for toileting and personal cares. Record review of the resident's POS, dated July 2020, showed: -On 7/10/20 new order for [MEDICATION NAME] 0.5 mg/2 ml one vial by nebulizer inhalation two times a day for seven days, [DIAGNOSES REDACTED]. night time dose found or documentation had been given on 7/13/20. 4. During interview on 7/14/20 at 12:00 P.M., Licensed Practical Nurse (LPN) A said he/she: -Had not started blood sugar checks for the unit yet. -CNA B was walking up the 100 hallway with small basket. During observation and interview of CNA B on 7/14/20 at 12:01 P.M., showed: -He/She placed a small basket onto the nursing medication cart. -The basket had accucheck supplies including a glucometer and lancets. -Also on the cart was a handwritten list of residents that had received their noon blood sugars checks including Resident #102 and Resident #100. -CNA B then went onto 200 hallway with CNA C. -CNA B was getting ready to enter a resident room. -CNA B had denied he/she obtained accuchecks for the residents on the 100 hall . -He/She said he/she just had placed basket on the nurse cart. -Observation of CNA B's left hand showed he/she had tubes of breathing treatment medication in his/her hand. -He/She said was allowed to provide a breathing treatment for [REDACTED]. -CNA B entered an isolation room on the right side of the 200 hall and shut the door. During interview on 7/14/20 at 12:06 P.M., LPN A said: -He/She had not performed the noon accuchecks for the residents on the 100 or 200 hall. -He/She was aware that CNA B was preparing and administering breathing treatments for the residents on the 100 and 200 halls. -CNA B was assisting him/her since he/she was the only licensed nurse on the unit. -He/She thought that CNA B was a medical assistant also and had been trained in providing blood sugars and nebulizer treatments. --NOTE: A list of the residents CNA B had provided breathing treatments for on 7/14/20 was requested from LPN A and not received at the time of exit. During interview on 7/14/20 at 12:30 P.M., Administrator said: -Would expect the CNA not to be performing blood sugar checks or breathing treatments. -CNA B was not certified as a Medical Assistant or a Certified Medication Technician (CMT). -The licensed nursing staff should not allow a CNA to provide licensed nursing skills. During an interview on 7/14/20 at 1:10 P.M., Resident #102 said: -CNA B had performed blood sugar testing and nebulizer treatments for the last three days, including 7/14/20. -Over the weekend of 7/10/14 to 7/13/20, CNA B was the only staff member that he/she was aware of on the evening shift. -CNA B was providing all the care for the residents that evening. -One staff had walked out due to the COVID-19, so the facility was short staffed. During an interview on 7/14/20 at 1:30 P.M., Resident #103 said CNA B had placed a medication in his/her nebulizer breathing machine for his/her treatment on 7/14/20. During an interview on 7/14/20 at 2:10 P.M., CNA C said: -CNAs should not perform a resident's breathing treatments or blood sugar checks monitoring. -Licensed Nursing staff completed all skilled nursing treatments. -No one had asked him/her to work out his/her scope of practice during the facility COVID-19 outbreak. During an interview on 7/14/20 at 2:13 P.M., Registered Nurse (RN) A said: -It is not in the CNA's scope of practice to perform resident's blood sugar checks or provide breathing treatments. -The CMT Medication Administration Record [REDACTED]. MO 536 and MO 591

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.