| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **455869** | A. BUILDING _____ B. WING _____ | **07/19/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **GUADALUPE VALLEY NURSING CENTER** | **1210 EASTWOOD DR SEGUIN, TX 78155** |

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

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| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to ensure Residents received treatment and care in accordance with professional standards of practice that met the physical, mental and psychological needs for 8 of 8 Residents (Resident # 3, 4, 5, 6, 7, 8, 9 and 10) reviewed for quality of care related to COVID-19 in that: 1. Resident #3 in the COVID-19 positive unit was not cared for by a licensed nurse from 4:30 p.m. to 10:00 p.m. on 7/13/20. Resident #3 had a decline in health and transferred to the hospital the following day. Resident #3 was not administered scheduled medications from 6:00 a.m. to 10:00 a.m. on 7/11/20. 2. Resident #4, #5, #6, #7, #8, #9 and #10 in the COVID-19 positive unit were not cared for by a licensed nurse from 4:30 p.m. to 10:00 p.m. on 7/13/20 and were not administered scheduled medications from 6:00 a.m. to 10:00 a.m. on 7/11/20. These failures resulted in identification of an Immediate Jeopardy (IJ) on 7/16/20. While the IJ was removed 7/18/20, the facility remained out of compliance at a level of actual harm with a scope identified as a pattern until interventions were put in place for all residents in the COVID-19 positive unit. Staff were in-serviced and increased nursing supervision was provided. These deficient practices affected residents in the COVID-19 positive unit and placed them at risk for harm, or death. The findings were: 1. a. Record review of Resident #3's face sheet, dated 7/15/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #3's most recent Quarterly MDS, dated [DATE], revealed the resident was moderately cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed 1-person physical assist with bed mobility and transfers. Record review of nursing note dated 7/14/20 at 9:03 a.m. by LVN A, revealed Resident #3 was assessed and noted with increased respirations, SpO2 (oxygen saturation) at 65% and O2 (oxygen) was administered at 2 liters. Record review of nursing note dated 7/14/20 at 9:48 a.m. by LVN A revealed orders were received for Resident #3 to be sent to the emergency room by ambulance for further evaluation and treatment. Record review of Resident #3's electronic record revealed no documentation in the nursing notes that the Resident was reported to have had a [MEDICAL CONDITION] or documentation of the Resident's vital signs reported by CNA F on 7/13/20. During an interview on 7/16/20 at 12:27 p.m., LVN B confirmed working on 7/13/20 from 5:20 a.m. to 9:25 p.m. LVN B revealed CNA E approached her at the nurse's station and told her he believed Resident #3, in the COVID-19 positive unit was having a [MEDICAL CONDITION]. LVN B stated, I never went to assess or investigate. LVN B further stated she did not know if a nurse was working in the COVID-19 positive unit at the time CNA E approached her about Resident #3. LVN B revealed I know that if somebody for sure had coded, you cannot go into the COVID unit without PPE and so by the time a nurse would have put on the PPE the resident would have been dead. During an interview on 7/16/20 at 1:04 p.m., CNA E revealed he worked on 7/13/20 from 10:00 a.m. to 6:40 p.m. CNA E revealed he was asked by CNA F at approximately 5:00 p.m. on 7/13/20 to get a nurse because she believed Resident #3 was having a [MEDICAL CONDITION]. CNA E stated he went out of the COVID-19 positive unit to the nurse's station where LVN B and LVN H were sitting. CNA E stated he told LVN B and LVN H that a nurse was needed in the COVID-19 positive unit because CNA F told him she believed Resident #3 was having a [MEDICAL CONDITION]. CNA E revealed that only LVN B acknowledged him. CNA E then asked LVN B to go to the COVID-19 positive unit to assess. CNA E stated LVN B did not go to the COVID-19 positive unit to assess Resident #3 and told him I'm not going, I'm not her nurse. CNA E then asked LVN B what nurse was in the charge of the COVID-19 positive unit, LVN B replied, I don't know. During an interview on 7/16/20 at 2:00 p.m., LVN A revealed she worked on the COVID-19 positive unit on 7/13/20 from 6 a.m. until 4:30 p.m. LVN A stated she informed the DON by phone she was leaving the COVID-19 positive unit and CNA F would be left there by herself. LVN A revealed she was told by the DON to give report to CNA F and told her don't worry, there's plenty of nurses in the building. LVN A confirmed she left the COVID-19 positive unit without being relieved by a licensed nurse. During an interview on 7/16/20 at 2:47 p.m., CNA F confirmed she worked on the COVID-19 positive unit on 7/13/20 from 6:00 a.m. to 10:00 p.m. CNA F stated LVN A was on speaker phone with the DON who instructed LVN A to give her (CNA F) report and then LVN A left the COVID-19 positive unit at 4:30 p.m. CNA F revealed she was passing out food trays between approximately 5:00 p.m. and 5:30 p.m. when she believed Resident #3 had displayed [MEDICAL CONDITION] activity. CNA F called CNA E into the COVID-19 positive unit to notify a nurse to assess. CNA F stated CNA E came back to the COVID-19 positive unit to inform her nobody was coming and LVN B told CNA E she would not go to the COVID-19 positive unit unless somebody was coding ([MEDICAL CONDITION]). CNA F stated she then called the nurse's station and LVN G picked up the phone. CNA F stated she told LVN G she believed Resident #3 was having [MEDICAL CONDITION] activity and had obtained the Resident's blood pressure and oxygen saturation. CNA F revealed she told LVN G Resident #3's blood pressure was high and oxygen level was low. LVN G instructed CNA F to go back and take Resident #3's temperature and to call her back. CNA F stated she obtained Resident #3's temperature and called back LVN G at the nurse's station who informed her she would notify the physician on call. CNA F revealed a licensed nurse did not come into the COVID-19 positive unit until 10:00 p.m. (PUT DOWN WHO THE NIGHT NURSE WAS) During an interview on 7/17/20 at 12:23 p.m. LVN H revealed CNA F was working on the COVID-19 positive unit on 7/13/20 but could not recall if a licensed nurse was working in the unit during the evening shift. LVN H stated the DON left the facility between 5:00 p.m. and 5:30 p.m. leaving LVN B, LVN G and herself in the facility during the evening shift on 7/13/20. LVN H confirmed she worked on 7/13/20 from 6:00 a.m. to 8:25 p.m. and did not go into the COVID-19 positive unit on 7/13/20. During an interview on 7/17/20 at 12:48 p.m., the DON confirmed she worked on 7/13/20 from 7:30 a.m. to 5:45 p.m. The DON revealed LVN A left the COVID-19 positive unit at approximately 5:00 p.m. on 7/13/20 leaving CNA F in the unit by herself. The DON further stated the night nurse was supposed to come in early and if unable had instructed LVN B and LVN H to go into the COVID-19 positive unit if CNA F needed help. The DON further stated she received a text message from LVN B about Resident #3 having had possible [MEDICAL CONDITION] activity and the DON texted back stating Please peek in the door and check on Resident #3. Assess her and see if she needs to be sent out. The DON stated LVN B texted back, CNA F said everything was fine. The DON stated she based the assumption that LVN B had gone into the COVID-19 positive unit to assess Resident #3 by LVN B's text message response. The DON revealed LVN I made the nursing schedule and was under the impression the night nurse would come in early. LVN I never said nobody was coming. The DON further revealed my back up plan was that if something occurred the nurses in the front would be able to help. During an interview on 7/17/20 at 2:22 p.m. LVN G confirmed she worked on 7/13/20 from 2:00 p.m. to 10:00 p.m. LVN G stated she answered a call from the phone in the nurse's station at approximately 6:30 p.m. or 7:30 p.m. from CNA F who was calling from the COVID-19 positive unit to inform her she believed Resident #3 had displayed [MEDICAL CONDITION] activity. LVN G instructed CNA F to take Resident #3's temperature and call her back. LVN G stated CNA F reported back by phone with Resident #3's temperature and informed CNA F she would notify the physician. LVN G confirmed she did not go into the COVID-19 positive unit to assess Resident #3 and did not document Resident #3's vital signs in the electronic record. LVN G further stated she did not document she had called the physician. |

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 0684

**Level of harm -** Immediate jeopardy

**Residents Affected -** Some

(continued... from page 1)
During an interview on 7/17/20 at 2:48 p.m., LVN I revealed she was in charge of making the nursing schedule. LVN I stated she received a call between 4:00 p.m. and 6:00 p.m. on 7/13/20 from LVN G informing her CNA F reported she believed Resident #3 in the COVID-19 positive unit had a [MEDICAL CONDITION]. LVN I stated LVN B was scheduled to work the COVID-19 positive unit on 7/13/20 with CNA F but LVN B refused. During an interview on 7/17/20 at 4:52 p.m., LVN D confirmed she worked the overnight shift beginning on 7/13/20 at 10:00 p.m. LVN D stated she was scheduled on the COVID-19 positive unit and when she came in at 10:00 p.m. there was nobody in the COVID unit. I did not get report from anybody. Record review of the nursing schedule for the COVID-19 positive unit on 7/13/20 revealed the following: -LVN A 6:00 a.m. to 4:15 p.m. -CNA F 6:00 a.m. to 10:00 p.m. -(Unassigned) Covid Nurse 4:15 p.m. to 10:00 p.m. b. Review of Resident #3's Physician order [REDACTED]. give 1 capsule by mouth one time a day, start date 8/5/19 - Potassium Chloride 20 meq give 1 tablet by mouth one time a day, start date 8/4/19 - [MEDICATION NAME] 10 mg give 1 tablet by mouth one time a day, start date 8/5/19 - [MEDICATION NAME] 50 mg give 1 tablet by mouth every 12 hours, start date 9/25/19 - [MEDICATION NAME] 10 mg give 1 tablet by mouth one time a day, start date 8/5/19 Review of Resident #3's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 20 mg, [MEDICATION NAME] 0.5 mg and [MEDICATION NAME] 125 mg at 8:00 a.m. on 7/11/20, [MEDICATION NAME] 60 mg, Potassium Chloride 20 meq, [MEDICATION NAME] 10 mg, [MEDICATION NAME] 50 mg and [MEDICATION NAME] 10 mg at 9:00 a.m. on 7/11/20. 2. a. Record review of Resident #4's Face Sheet, dated 7/17/20, revealed an admission date of [DATE] and re-admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #4's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 5 which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed Resident #4 required 1-person physical assist with bed mobility and transfers. Review of Resident #4's Physician order [REDACTED]. Review of Resident #4's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 50 mg at 8:00 a.m. on 7/11/20. b. Record review of Resident #5's Face Sheet, dated 7/17/2020, revealed an admission date of [DATE] and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's Quarterly MDS dated [DATE], revealed a BIMS of 6 which indicated severe cognitive impairment. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with bed mobility and transfers. Review of Resident #5's Physician order [REDACTED]. mg give 1 tablet by mouth one time a day, start date 10/1/2018 -[MEDICATION NAME] capsule 100 mg give 1 capsule by mouth two times a day, start date 10/1/2018. Review of Resident #5's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of Aspirin 81 mg, [MEDICATION NAME] 1000-unit, [MEDICATION NAME] ER 50 mg, [MEDICATION NAME] Chloride ER 10 mg, [MEDICATION NAME] 100 mg, on 7/11/2020 at 8:00 a.m. c. Record review of Resident #6's Face Sheet, dated 7/15/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #6's most recent Admission MDS, dated [DATE], revealed a BIMS score of 1 which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Admission MDS revealed the Resident required extensive assistance with bed mobility and transfers. Review of Resident #6's Physician order [REDACTED]. three times a day, start date 6/15/20 Review of Resident #6's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 25 mg, Losartan 100 mg, [MEDICATION NAME] 1000 mg and [MEDICATION NAME]-[MEDICATION NAME] 25 mg-100 mg at 9:00 a.m. on 7/11/20. d. Record review of Resident #7's Face Sheet, dated 7/16/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #7's Admission MDS dated [DATE] revealed a BIMS of 12 which indicated moderately impaired cognition. Further review of the Admission MDS revealed the Resident required 1-person physical assist with bed mobility and transfers. Review of Resident #7's Physician order [REDACTED].#7's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration [MEDICATION NAME] 40 mg, Losartan Potassium 100 mg on 7/11/2020 at 9:00 a.m. e. Record review of Resident #8's Face Sheet, dated 7/17/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #8's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 4, which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with bed mobility and 2-person physical assist with transfers. Review of Resident #8's Physician order [REDACTED]. Review of Resident #8's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] Nebulization Solution 2.5 mg/3 ml at 6:00 a.m. on 7/11/20. f. Record review of Resident #9's Face Sheet, dated 7/18/2020 revealed an admission of 11/29/2012 and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly MDS dated [DATE] revealed a BIMS of 10 which indicated moderately impaired cognition. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with bed mobility and transfers. Review of Resident #9's Physician order [REDACTED]./24/2020 Review of Resident #9's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 2 mg on 7/11/2020 at 8:00 a.m. and [MEDICATION NAME] ointment treatment to right heel on 7/13/2020 and 7/14/2020 at 9:00 a.m. Observation on 7/15/2020 at 3:50 p.m. of Resident #9 's right heel revealed a clean, dry, calloused, unopened area on the bottom of the Resident's right heel with no drainage or redness apparent around the area. Interview with Resident #9 on 7/15/2020 at 3:50 p.m. during observation of the right heel she revealed that a foot doctor attended to her heel and had treatment for [REDACTED]. g. Record review of Resident #10's Face Sheet, dated 7/16/2020 revealed an admission of 9/18/2019 and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #10's Significant Change MDS, dated [DATE], revealed a BIMS of 13 which indicated cognitively intact. Further review of the MDS revealed the Resident required a 2-person physical assist with bed mobility and transfers. Review of Resident #10's Physician order [REDACTED]. by mouth one time a day, start date 11/11/2019 -[MEDICATION NAME] Chloride 5 mg give 1 tablet by mouth two times a day, start date 4/2/2020 Review of Resident #10's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] Bisulfate 75 mg, [MEDICATION NAME] Powder 3350, Vitamin B12 500 mcg, Vitamin D3 1000 unit and [MEDICATION NAME] Chloride 5 mg on 7/11/2020 at 9:00 a.m. During an interview on 7/12/2020 at 10:50 a.m. LVN C stated she was not scheduled to work on the COVID unit on 7/11/2020 but was assigned to the unit by the Administrator from 10:00 a.m. until 10:00 p.m. on 7/11/2020 as LVN H, who was scheduled to work the unit from 6 a.m. - 6 p.m., had called in and would not be working. She confirmed that she had not administered any medications prior to 10:00 a.m. on 7/11/2020 to COVID Residents #3, #4, #5, #6, #7, #8, #9 and #10. During an interview on 7/14/2020 at 1:59 p.m. the Administrator confirmed there had not been a designated nurse on the COVID unit from 6:00 - 10:00 a.m. on 7/11/2020 and that medications scheduled from 6:00 a.m. - 10:00 a.m. were not administered to residents (#3, #4, #5, #6, #7, #8, #9, #10) on the COVID unit. During an interview on 7/15/2020 at 11:13 a.m. with LVN B she confirmed she worked in the facility on 7/11/2020 in the morning but did not work on the COVID unit and did not administer any scheduled medications from 6:00 a.m. - 10:00 a.m. to the COVID unit residents. During an interview on 7/16/2020 at 2:00 p.m. LVN A stated she didn't realize that Resident #9 had a 9:00 a.m. wound treatment order for the right heel. LVN A confirmed she had not done the wound treatment on 7/13/2020 and 7/14/2020 at 9:00 a.m. During an interview on 7/17/2020 at 3:30 p.m. the Interim DON confirmed there were no signatures of staff on Resident #3, 4, 5, 6, 7, 8, 9 and 10"s July MAR indicated [REDACTED]. Facility staff should comply with the facility policy, applicable law and the State Operations Manual when administering medications. On 7/16/20 at 6:15 p.m. the Administrator, Assisting Administrator, Clinical Specialist and Assisting DON were notified of an Immediate Jeopardy (IJ) situation for the above failure, a completed IJ template was provided and a Plan of Removal was requested. On 7/17/20 at 6:38 p.m. the facility's Plan of Removal was approved. The facility's Plan of Removal included the following steps to be taken by the facility: 1. Assessments for current COVID-19 residents completed by a licensed nurse 7/16/20. 2. Abuse, Neglect, Exploitation in-service completed 7/16/20 and 7/17/20. 3. 10 Rights of Medication Administration in-service completed 7/16/20-7/17/20. 4. Change of shift expectations which included verbal report, medical record review and staffing concerns in-service completed 7/16/20-7/17/20. 5. Medication and Treatment records were audited by the Interim DON for compliance and the Medical Director notification 7/16/20. 6. Medical Director notified of Immediate Jeopardy 7/16/20 per interview with the Administrator and the Interim DON. 7. Interim DON daily monitoring of staffing coverage on COVID-19 unit 7/16/20. The surveyor verification of the Plan of Removal on 7/18/2020 was as follows: Interview with the Clinical Specialist and records reviewed of 10 COVID-19 positive residents revealed completion of assessments. Review of in-service records revealed Abuse, Neglect and Exploitation training provided and documented for staff. Review of in-service records revealed 10 Rights of Medication Administration training provided and documented for staff. Review of in-service records revealed change of shift expectations training was provided and documented for staff. Review of Medication Administration Audit Report revealed 8 COVID-19 positive resident's medication error/missed medications had been reported to the Medical Director. Interview with the Interim DON revealed daily monitoring for staffing coverage in the COVID-19 unit would be monitored daily. Observation on the COVID-19 unit revealed 1

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| F 0684<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 2)<br>licensed nurse and 1 CNA scheduled per shift 7/18/20. Record review revealed implementation of new staffing schedule. Medication and Treatment records reviewed for all COVID-19 positive residents revealed medications and treatments administered as scheduled 7/16/20 to 7/18/20. In-service sign-in sheets and material covered by the in-services were reviewed onsite 7/18/20 included Abuse, Neglect, Exploitation Policy, designated licensed nursing coverage in the COVID-19 positive unit, 10 rights of medication administration, change of shift expectations to include verbal report, medical record review, DON/Administration and follow up to address staffing concerns by the Interim DON, medication and treatments records audited for compliance and physician notification if medications are missed, DON/designee daily monitoring of nursing coverage in the COVID-19 positive unit, DON/designee monitoring of the electronic record medication and treatment record audits of COVID-19 positive residents three times a week. Staff interviews were conducted in a private office on 2 different shifts. Interviews occurred on 7/18/20 from 1:21 p.m. - 3:07 p.m. with 9 CNA's, 7 LVN's, 1 RN, 1 Social Worker, 1 Physical Therapist Assistant, the Interim DON and Administrator. All stated they had received in-services regarding Abuse, Neglect and Exploitation, in-service regarding the 10 rights of medication, change of shift expectations to include verbal report, medical record review and staffing concerns, reporting medication errors/missed medications, DON daily monitoring of staffing coverage including the COVID-19 positive unit and use of new scheduling system. On 7/18/20 at 6:41p.m. the Administrator was informed the IJ was removed. However, the facility remained out of compliance at a severity of actual harm with a scope identified as pattern until all staff were in-serviced. |
| F 0727<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.**<br><br>Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week in that; The facility failed to maintain RN coverage on 6/14/2020 and 6/28/2020. This failure could affect residents of the facility by placing them at risk for not having their nursing and medical needs met. The findings were: Review of the Employee Time Card for the facility RN's from 5/31/2020 - 7/11/2020 revealed there was no RN coverage on Sunday, 6/14/2020 and Sunday, 6/28/2020. Interview with the Administrator on 7/14/2020 at 1:59 p.m. confirmed there was no RN present in the building for 8 hours on 6/14/2020 and 6/28/2020. Interview with the Interim DON on 7/15/2020 at 1:50 p.m. stated there was no written facility policy for RN staffing 8-hour daily coverage and that the facility followed the federal/state regulation expectations. |
| F 0755<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to provide pharmaceutical services to include procedures that assure the accurate administration and documentation of medications for 10 of 12 (Resident #3, #4, #5, #6, #7, #8, #9, and #10) whose medications were reviewed in that: Resident #3, #4, #5, #6, #7, #8, #9 and #10 were not administered medications on 7/11/20 and Resident #9 was not administered medications on 7/13/20 and 7/14/20 as ordered by the physician. This deficient practice could affect residents and place them at risk in a decline in their health. The findings were: a. Record review of Resident #3's face sheet, dated 7/15/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #3's most recent Quarterly MDS, dated [DATE], revealed the resident was moderately cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed 1-person physical assist with bed mobility and transfers. Review of Resident #3's Physician order [REDACTED]. give 1 capsule by mouth one time a day, start date 8/5/19 - Potassium Chloride 20 meq give 1 tablet by mouth one time a day, start date 8/4/19 - [MEDICATION NAME] 10 mg give 1 tablet by mouth one time a day, start date 8/5/19 - [MEDICATION NAME] 50 mg give 1 tablet by mouth every 12 hours, start date 9/25/19 - [MEDICATION NAME] 10 mg give 1 tablet by mouth one time a day, start date 8/5/19 Review of Resident #3's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 20 mg, [MEDICATION NAME] 0.5 mg and [MEDICATION NAME] 125 mg at 8:00 a.m. on 7/11/20, [MEDICATION NAME] 60 mg,<br>Potassium Chloride 20 meq, [MEDICATION NAME] 10 mg, [MEDICATION NAME] 50 mg and [MEDICATION NAME] 10 mg at 9:00 a.m. on<br>7/11/20. b. Record review of Resident #4's Face Sheet, dated 7/17/20, revealed an admission date of [DATE] and re-admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #4's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 5 which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed Resident #4 required 1-person physical assist with bed mobility and transfers. Review of Resident #4's Physician order [REDACTED]. Review of Resident #4's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 50 mg at 8:00 a.m. on 7/11/20. c. Record review of Resident #5's Face Sheet, dated 7/17/2020, revealed an admission date of [DATE] and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's Quarterly MDS dated [DATE], revealed a BIMS of 6 which indicated severe cognitive impairment. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with bed mobility and transfers. Review of Resident #5's Physician order [REDACTED]. mg give 1 tablet by mouth one time a day, start date 10/1/2018 -[MEDICATION NAME] capsule 100 mg give 1 capsule by mouth two times a day, start date 10/1/2018. Review of Resident #5's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of Aspirin 81 mg, [MEDICATION NAME] 1000-unit, [MEDICATION NAME] ER 50 mg, [MEDICATION NAME] Chloride ER 10 mg, [MEDICATION<br>NAME] 100 mg, on 7/11/2020 at 8:00 a.m. d. Record review of Resident #6's Face Sheet, dated 7/15/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #6's most recent Admission MDS, dated [DATE], revealed a BIMS score of 1 which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Admission MDS revealed the Resident required extensive assistance with bed mobility and transfers. Review of Resident #6's Physician order [REDACTED]. three times a day, start date 6/15/20 Review of Resident #6's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 25 mg, Losartan 100 mg, [MEDICATION NAME] 1000 mg and [MEDICATION NAME]-[MEDICATION NAME] 25 mg-100 mg at 9:00 a.m. on 7/11/20. e. Record review of Resident #7's Face Sheet, dated 7/16/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED].<br>Review of Resident #7's Admission MDS dated [DATE] revealed a BIMS of 12 which indicated moderately impaired cognition. Further review of the Admission MDS revealed the Resident required 1-person physical assist with bed mobility and transfers. Review of Resident #7's Physician order [REDACTED].#7's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration [MEDICATION NAME] 40 mg, Losartan Potassium 100 mg on 7/11/2020 at 9:00 a.m. f. Record review of Resident #8's Face Sheet, dated 7/17/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #8's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 4,<br>which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with bed mobility and 2-person physical assist with transfers. Review of Resident #8's Physician order [REDACTED]. Review of Resident #8's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] Nebulization Solution 2.5 mg/3 ml at 6:00 a.m. on 7/11/20. g. Record review of Resident #9's Face Sheet, dated 7/18/2020 revealed an admission of 11/29/2012 and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly MDS dated [DATE]<br>revealed a BIMS of 10 which indicated moderately impaired cognition. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with bed mobility and transfers. Review of Resident #9's Physician order [REDACTED]./24/2020 Review of Resident #9's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 2 mg on 7/11/2020 at 8:00 a.m. and [MEDICATION NAME] ointment treatment to<br>right heel on 7/13/2020 and 7/14/2020 at 9:00 a.m. Observation on 7/15/2020 at 3:50 p.m. of Resident #9 's right heel revealed a clean, dry, calloused, unopened area on the bottom of the Resident's right heel with no drainage or redness apparent around the area. Interview with Resident #9 on 7/15/2020 at 3:50 p.m. during observation of the right heel she revealed that a foot doctor attended to her heel and had treatment for [REDACTED]. h. Record review of Resident #10's Face Sheet, dated 7/16/2020 revealed an admission of 9/18/2019 and readmission date of [DATE] with [DIAGNOSES REDACTED]. Review<br>of Resident #10's Significant Change MDS, dated [DATE], revealed a BIMS of 13 which indicated cognitively intact. Further review of the MDS revealed the Resident required a 2-person physical assist with bed mobility and transfers. Review of |

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| | **455869** | A. BUILDING _____ B. WING _____ | **07/19/2020** |

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| F 0755<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>Resident #10's Physician order [REDACTED]. by mouth one time a day, start date 11/11/2019 -[MEDICATION NAME] Chloride 5 mg give 1 tablet by mouth two times a day, start date 4/2/2020 Review of Resident #10's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] Bisulfate 75 mg, [MEDICATION NAME] Powder 3350, Vitamin B12 500 mcg, Vitamin D3 1000 unit and [MEDICATION NAME] Chloride 5 mg on 7/11/2020 at 9:00 a.m. During an interview on 7/12/2020 at 10:50 a.m. LVN C stated she was not scheduled to work on the COVID unit on 7/11/2020 but was assigned to the unit by the Administrator from 10:00 a.m. until 10:00 p.m. on 7/11/2020 as LVN H, who was scheduled to work the unit from 6 a.m. - 6 p.m., had called in and would not be working. She confirmed that she had not administered any medications prior to 10:00 a.m. on 7/11/2020 to COVID Residents #3, #4, #5, #6, #7, #8, #9 and #10. During an interview on 7/14/2020 at 1:59 p.m. the Administrator confirmed there had not been a designated nurse on the COVID unit from 6:00 - 10:00 a.m. on 7/11/2020 and that medications scheduled from 6:00 a.m. - 10: a.m. were not administered to residents ((#3, #4, #5, #6, #7, #8, #9, #10) on the COVID unit. During an interview on 7/15/2020 at 11:13 a.m. with LVN B she confirmed she worked in the facility on 7/11/2020 in the morning but did not work on the COVID unit and did not administer any scheduled medications from 6:00 a.m. - 10:00 a.m. to the COVID unit residents. During an interview on 7/16/2020 at 2:00 p.m. LVN A stated she didn't realize that Resident #9 had a 9:00 a.m. wound treatment order for the right heel. LVN A confirmed she had not done the wound treatment on 7/13/2020 and 7/14/2020 at 9:00 a.m. During an interview on 7/17/2020 at 3:30 p.m. the Interim DON confirmed there were no signatures of staff on Resident #3, 4, 5, 6, 7, 8, 9 and 10"s July MAR indicated [REDACTED]. Facility staff should comply with the facility policy, applicable law and the State Operations Manual when administering medications .6.1. Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms. |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to assure drugs and biologicals were secured properly for 2 of 2 residents (Resident #3, #12), in that: 1. There were 3 medication blister packs of [MEDICATION NAME] 125 mg capsules, [MEDICATION NAME] 20 mg tablets and [MEDICATION NAME] 10 mg tablets prescribed for Resident #3 left unattended on a table outside the 600 unit. 2. There were 2 insulin pens prescribed for Resident #12 left unattended on a table outside the 600 unit. This deficient practice could place residents who received medications at risk for not receiving prescribed medications and for not receiving the intended therapeutic benefit of their medications as ordered. The findings were: 1. Record review of Resident #3's face sheet, dated 7/15/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #3's Physician order [REDACTED]. During an interview on 7/15/20 at 10:57 a.m., the Interim DON confirmed the 3 medication blister packs belonged to Resident #3 and further revealed she did not know who had left them there. During an interview on 7/15/20 at 12:05 p.m., LVN B confirmed she left 3 medication blister packs belonging to Resident #3 on the table outside the 600 unit. LVN B further revealed she put the medications down on the table and forgot about them. 2. Record review of Resident #12's face sheet, dated 7/15/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #12's Physician order [REDACTED]. During an interview on 7/15/20 at 10:57 a.m., the Interim DON confirmed the 2 insulin pens belonged to Resident #3 and further revealed she did not know who had left them there. During an interview on 7/15/20 at 12:05 p.m., LVN B confirmed she left 2 insulin pens belonging to Resident #3 on the table outside the 600 unit. LVN B further revealed she put the medications down on the table and forgot about them. During an interview on 7/15/20 at 1:52 p.m. the Interim DON revealed it was the expectation of nursing staff to lock medications at all times and not leave unattended. Review of the policy General Dose Preparation and Medication Administration dated 2017 revealed in part .6.1. Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms. |
| F 0813<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Have a policy regarding use and storage of foods brought to residents by family and other visitors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review there was no facility personal food policy in place to ensure safe and sanitary storage of resident's food and beverage items for 2 of 2 Residents (Resident #1 and #2) reviewed for personal food in that: 1. Resident #1's personal in-room refrigerator was not monitored for safe temperatures. 2. Resident #2's personal in-room refrigerator was not monitored for safe temperatures or expired food. This deficient practice could place residents who had personal in-room refrigerators at risk of food borne illnesses. The findings were: 1. Record review of Resident #1's Face Sheet, dated [DATE], revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #1's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 3, which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with eating. Record review of Resident #1's Order Summary Report, dated [DATE], revealed an order for [REDACTED].#1's room with a thermometer gauge on top of the in-room refrigerator and a taped document on the in-room refrigerator door titled Refrigerator Temperature Log dated February 2020 with one documented entry dated [DATE]. During observation and interview on [DATE] at 2:53 p.m. the DON confirmed the in-room refrigerator belonged to Resident #1. The DON confirmed the temperature gauge was on top of the in-room refrigerator and not inside. The DON further revealed the temperature logs for the in-room refrigerator for Resident #1 was at the nurse's station but could not locate it. The DON revealed we don't check the food items, we just check the temps, obviously it's not being done. 2. Record review of Resident #2's Face Sheet, dated [DATE], revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's most recent Quarterly MDS, dated [DATE] revealed a BIMS score of 2 which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with eating. During observation and interview on [DATE] at 3:04 p.m. the DON confirmed the in-room refrigerator belonged to Resident #2. The DON confirmed the taped document on the in-room refrigerator door titled Refrigerator Temperature Log dated February 2020 had one documented entry dated [DATE]. Observation with the DON revealed 2 cups of pudding without a label and 1 cup of fruit with expiration date of [DATE]. The DON confirmed food items were not being checked in the in-room refrigerators and checking the refrigerator temperature obviously it's not being done. During an interview with the Administrator on [DATE] at 4:09 p.m. he confirmed the facility did not have a policy for the resident's use of in-room refrigerators. |
| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interviews, and record reviews, the facility failed to maintain clinical records that were complete and accurate, in accordance with accepted professional standards and practices, for 10 of 12 residents (Resident #3, #4, #5, #6, #7, #8, #9, #10, #11 and #12) whose medical records were reviewed in that: 1. Resident #3's Medication Administration Record [REDACTED]. 2. Resident #4's Medication Administration Record [REDACTED]. 3. Resident #5's Medication Administration Record [REDACTED]. 4. Resident #6's Medication Administration Record [REDACTED]. 5. Resident #7's Medication Administration Record [REDACTED]. 6. Resident #8's Medication Administration Record [REDACTED]. 7. Resident #9's Medication Administration Record [REDACTED]. 8. Resident #10's Medication Administration Record [REDACTED]. 9. Resident #11's Treatment Administration Record (TAR) for July 2020 did not reflect accurate documentation of treatment administration. 10. Resident #12's |

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| F 0842<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>Medication Administration Record [REDACTED]. The findings were: 1. Record review of Resident #3's face sheet, dated 7/15/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #3's most recent Quarterly MDS, dated [DATE], revealed the resident was moderately cognitively impaired for daily decision-making skills Record review of Resident #3's Order Summary, dated 7/15/20, revealed the following orders: - [MEDICATION NAME] 20 mg give 1 tablet by mouth one time a day, start date 10/12/19 - [MEDICATION NAME] 0.5 mg give 1 tablet by mouth two times a day, start date 4/6/20 - [MEDICATION NAME] 125 mg give 1 capsule by mouth three times a day, start date 5/11/20 - [MEDICATION NAME] Capsule Delayed Release Particles 60 mg give 1 capsule by mouth one time a day, start date 8/5/19 - Potassium Chloride 20 meq give 1 tablet by mouth one time a day, start date 8/4/19 - [MEDICATION NAME] 10 mg give 1 tablet by mouth one time a day, start date 8/5/19 - [MEDICATION NAME] 50 mg give 1 tablet by mouth every 12 hours, start date 9/25/19 - [MEDICATION NAME] 10 mg give 1 tablet by mouth one time a day, start date 8/5/19 Review of Resident #3's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 20 mg, [MEDICATION NAME] 0.5 mg and [MEDICATION NAME] 125 mg at 8:00 a.m. on 7/11/20, [MEDICATION NAME] 60 mg, Potassium Chloride 20 meq, [MEDICATION NAME] 10 mg, [MEDICATION NAME] 50 mg and [MEDICATION NAME] 10 mg at 9:00 a.m. on 7/11/20. Interview on 7/17/2020 at 3:30 p.m. with the Interim DON confirmed no signatures of staff on the July MAR for Resident #3 on 7/11/2020 at 8:00 a.m. and 9:00 a.m. and it appeared that the medications were not administered. 2. Record review of Resident #4's Face Sheet, dated 7/17/20, revealed an admission date of [DATE] and re-admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #4's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 5 which indicated the Resident was severely cognitively impaired for daily decision-making skills. Record review of Resident #4's Order Summary, dated 7/17/20, revealed the following orders: - [MEDICATION NAME] 50 mg give 1 tablet by mouth two times a day, start date 6/4/20. Review of Resident #4's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 50 mg at 8:00 a.m. on 7/11/20. Interview on 7/17/2020 at 3:30 p.m. with the Interim DON confirmed no signatures of staff on the July MAR for Resident #4 on 7/11/2020 at 8:00 a.m. and it appeared that the medications were not administered. 3. Record review of Resident #5's face sheet, dated 7/17/2020, revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #5's Quarterly MDS dated [DATE] revealed a BIMS of 6 which indicated severe cognitive impairment. Review of Resident #5's Physician order [REDACTED]. mg give 1 tablet by mouth one time a day, start date 10/1/2018 -[MEDICATION NAME] capsule 100 mg give 1 capsule by mouth two times a day, start date 10/1/2018. -Atorvastatin Calcium 20 mg give 1 tablet by mouth at bedtime, start date 6/19/2020. Review of Resident #5's July 2020 MAR indicated [REDACTED]. Interview on 7/17/2020 at 3:30 p.m. with the Interim DON confirmed no signatures of staff on the July MAR for Resident #5 on 7/11/2020 8:00 a.m. medications and on 7/12/2020 for the bedtime medication and it appeared that the medications were not administered. 4. Record review of Resident #6's Face Sheet, dated 7/15/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #6's most recent Admission MDS, dated [DATE], revealed a BIMS score of 1 which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Admission MDS revealed the Resident required extensive assistance with bed mobility and transfers. Review of Resident #6's Physician order [REDACTED]. three times a day, start date 6/15/20 Review of Resident #6's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] 25 mg, Losartan 100 mg, [MEDICATION NAME] 1000 mg and [MEDICATION NAME]-[MEDICATION NAME] 25 mg-100 mg at 9:00 a.m. on 7/11/20. 5. Record review of Resident #7's face sheet, dated 7/16/2020 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #7's Admission MDS dated [DATE] revealed a BIMS of 12 which indicated moderately impaired cognition. Review of Resident #7's Physician order [REDACTED]. tablet by mouth at bedtime, start date 7/7/2020. Review of Resident #7's July 2020 MAR indicated [REDACTED]#7's 9:00 p.m. [MEDICATION NAME] injection on 7/14/2020 and may have missed documenting the administration on the resident's MAR indicated [REDACTED]. Interview on 7/17/2020 at 3:30 p.m. with the Interim DON confirmed no signatures of staff on the July MAR for Resident #7 on 7/11/2020 9:00 a.m. medications, 7/10/2020. 7/12/2020, 7/13/2020 and 7/14/2020 9:00 p.m. medications and it appeared that the medications were not administered. 6. Record review of Resident #8's Face Sheet, dated 7/17/20, revealed an admission date of [DATE], with [DIAGNOSES REDACTED]. Record review of Resident #8's most recent Quarterly MDS, dated [DATE], revealed a BIMS score of 4, which indicated the Resident was severely cognitively impaired for daily decision-making skills. Further review of the Quarterly MDS revealed the Resident required 1-person physical assist with bed mobility and 2-person physical assist with transfers. Review of Resident #8's Physician order [REDACTED]. Review of Resident #8's July 2020 MAR (Medication Administration Record) revealed no signature of staff indicating administration of [MEDICATION NAME] Nebulization Solution 2.5 mg/3 ml at 6:00 a.m. on 7/11/20. 7. Record review of Resident #9's face sheet dated 7/18/2020 revealed the resident was admitted to the facility on [DATE] and readmitted on 6/18/2017 with [DIAGNOSES REDACTED]. Review of Resident #9's Quarterly MDS dated [DATE] revealed a BIMS of 10 which indicated moderately impaired cognition. Review of Resident #9's Physician order [REDACTED]. and left lower extremity with normal saline, apply [MEDICATION NAME] ointment to right heel and left lower extremity, cover right heel, leave left lower extremity open to air one time a day, start date 5/24/2020 Review of Resident #9's July 2020 MAR indicated [REDACTED]#9 had a 9:00 a.m. wound treatment for [REDACTED].#9 on 7/6/2020 5:00 p.m. medication, 7/11/2020 8:00 a.m. medication, 7/12/2020 8:00 p.m. medication, 7/1/2020, 7/2//2020, 7/13/2020 and 7/14/2020 9:00 a.m. wound treatment and it appeared that the medications were not administered. 8. Record review of Resident #10's face sheet, dated 7/16/2020 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #10's Significant Change MDS, dated [DATE], revealed a BIMS of 13 which indicated cognitively intact. Review of Resident #10's Physician order [REDACTED]. at bedtime, start date 5/15/2020 -Vitamin B12 500 mcg give 1 tablet by mouth one time a day, start date11/11/2019 -Vitamin D3 1000 unit give 1 tablet by mouth one time a day, start date 11/11/2019 -[MEDICATION NAME] Chloride 5 mg give 1 tablet by mouth two times a day, start date 4/2/2020 Review of Resident #10's July 2020 MAR indicated [REDACTED]#10 on 7/11/2020 9:00 p.m. medications, 7/12/2020 8:00 p.m. and 9:00 p.m. medications and it appeared the medications were not administered. 9. Record review of Resident #11's face sheet, dated 7/16/2020 revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #11's Significant Change MDS dated [DATE] revealed a BIMS of 2 which indicated severe cognitive impairment. Review of Resident #11's Physician order [REDACTED]. Review of Resident #11's July 2020 MAR indicated [REDACTED]. Interview on 7/17/2020 at 3:30 p.m. with the Interim DON confirmed no signature of staff on the July MAR for Resident #11 on 7/1/2020, 7/2/2020, 7/3/2020, 7/11/2020 and 7/12/2020 day shift treatment medication and 7/4/2020, 7/6 2020, 7/9/2020, 7/10/2020, 7/13/2020 and 7/14/2020 night shift treatment medication and it appeared the medication was not administered. 10. Record review of Resident #12's face sheet, dated 7/15/20, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #12's most recent Quarterly MDS, dated [DATE] revealed a BIMS score of 10 which indicated the Resident was moderately cognitively impaired for daily decision-making skills. Review of Resident #12's Physician order [REDACTED]. capsule by mouth three times a day every Monday, Wednesday, Friday and Sunday, start date 3/6/20 -[MEDICATION NAME] 30 mg give 30 mg by mouth at bedtime, start date 3/18/20 -Humolog KwikPen Solution Pen-injector 100 units/ml inject 20 units subcutaneously two times a day every Tuesday, Thursday and Saturday, start date 2/18/20 -Humolog Solution 100 units/ml inject as per sliding scale subcutaneously three times a day every Tuesday, Thursday, and Saturday, start date 2/13/20 Review of Resident #12's July 2020 MAR indicated [REDACTED]#12 revealed she believed she was not getting her medications and further revealed she needed her Eliquis medication because I have had blood clots before. Interview on 7/17/2020 at 3:30 p.m. with the Interim DON confirmed no signature of staff on the July MAR for Resident #12 on 7/12/2020 8:00 p.m. medications and 7/14/2020 11:00 a.m. medications and it appeared the medications were not administered. Review of the policy General Dose Preparation and Medication Administration dated 2017 revealed in part .6.1. Document necessary medication administration/treatment information (e.g. when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight) on appropriate forms. |

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| 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><br>Based on observations, interviews and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections including COVID-19 in that: 1. LVN J did not wear a face mask while in the facility. 2. ABOM K did not wear a face mask properly covering her nose or mouth while in the facility. These deficient practices could place all residents, staff and visitors at risk of transmission of communicable diseases and infections, including COVID-19. The findings were: 1. Observation on 6/18/20 at 11:01 a.m. revealed LVN J walked out of an office |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 5)<br>across from the nurse's station and walked into the nurse's station without wearing a face mask. During an interview on 6/18/20 at 11:40 a.m., the DON confirmed she observed LVN J not wearing a face mask and asked her to put one on. The DON further stated the expectation of all staff was to wear a face mask at all times during their shift. During an interview on 6/18/20 at 12:00 p.m., LVN J confirmed she did not have her face mask on when she walked into the nurse's station. LVN J further revealed she had been in-serviced on the use of face masks and was basically told to wear it all the time. 2. Observation on 6/18/20 at 11:59 a.m. revealed ABOM K sitting at the front desk by the facility entrance with her face mask not covering her nose or mouth. During an interview on 6/18/20 at 12:15 p.m. ABOM K stated she screened visitors and staff for COVID-19 symptoms prior to allowing them entry into the facility. ABOM K further stated she pulled her face mask down to drink some water but had not gotten in the habit of pulling it right back up. ABOM K stated she had been in-serviced on the proper use of a face mask and that it should be worn at all times during the shift. Interview on 7/18/20 at 4:34 p.m. with the Assisting Administrator revealed the facility referenced the HHSC COVID-19 Response for Nursing Facilities, version 3.1 for the use of face masks. Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/20, revealed in part .HCP (Health Care Professionals) should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers . |