| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265258 | A. BUILDING _____ B. WING _____ | 03/13/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BELLEVIEW VALLEY NURSING HOME | 23144 HIGHWAY 32 BELLEVIEW, MO 63623 |

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 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><br>Based on interview and record review, the facility failed to document a complete and accurate Minimum Data Set (MDS; a federally mandated assessment to be completed by the facility), for three residents (Resident #6, #14, and #51) out of 20 sampled residents. The facility's census was 99. 1. Record review of Resident #6's nurse's notes showed: - On 10/6/19, this resident attempted to elope from facility. Resident brought back in; - On 11/10/19, this resident states his/her roommate called his/her a name and went out the door on B Hall, 911 was called. Record review of the resident's comprehensive care plan, reviewed/revised 1/7/20, showed: - [DIAGNOSES REDACTED].: resident had elopement in previous history, last revised 12/16/19. Record review of the resident's MDS showed: - Discharge MDS dated [DATE]: - Section E900 Wandering - marked as behavior not exhibited; - Section E1000 Wandering Impact - not answered; - Discharge MDS dated [DATE]: - Section E900 Wandering - marked as behavior not exhibited; - Section E1000 Wandering Impact - not answered; - Quarterly MDS dated [DATE]: - Section E900 Wandering - marked as behavior not exhibited; - Section E1000 Wandering Impact - not answered; - The MDSs did not address wandering and behaviors. 2. Record review of Resident #14's nurse's notes showed: - On 10/1/19, resident yelling found sitting in floor next to bed, skin tears to right forearm times four; - On 10/13/19, resident laying his/her back with cut to left eyebrow; - On 11/19/19, found resident in floor next to bed sitting on buttock, skin tear on right hand and wrist. Record review of the resident's March 2020 physician's orders [REDACTED].-harm or harm to others); - May use wheelchair when weak/unsteady gait. Record review of the resident's Quarterly MDS, dated [DATE], showed: - Section J1900A Fall marked with no injury - 1; - Section J1900B Fall marked with injury (skin tears, lacerations) - 0; - The MDS did not show an accurate assessment of the falls with injuries. 3. Record review of Resident #51's March 2020 POS showed: - [DIAGNOSES REDACTED]. affective disorder (a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression); - Order for wheelchair when weak or unsteady gait. Record review of the resident's nurse's notes showed: - On 12/21/19, resident found laying on floor at doorway, when asked he/she states he/she was trying to plug in phone behind bed and lost balance. Did not hit head, landed on bottom. Assessment full range of motion (ROM) denies any injuries at this time. Call placed to guardian, unable to get through with four attempts. Hospice notified physician, no redness or marks noted. Vital Signs, blood pressure 130/70, pulse 70, [MED]gen saturation 93% on room air. Record review of the resident's quarterly MDS dated [DATE] showed: - Section G (Functional status-Activities of Daily Living-ADLs) marked as limited assistance of one staff for locomotion on unit; - Section J1700 (Falls) marked as no falls; - The MDS did not show an accurate assessment of the falls with injuries. 4. During an interview on 3/13/20 at 9:55 A.M., the MDS Coordinator said she would expect each MDS to be accurately completed including the correct number of falls and falls with injuries in Section J and wandering and elopement behaviors in Section E. 5. The facility did not provide a policy regarding MDS accuracy. |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to develop and implement care plans for one resident (Resident #71) out of 20 sampled residents. The facility's census was 99. 1. Record review of Resident #71's March 2020 physician's orders [REDACTED]. Record review of Resident #71's medical records showed: - On 12/31/19, a Pre-Restraining Evaluation completed for side rails; - On 12/31/19, the facility completed a side rail assessment; - The care plan did not address the use of side rails or OT. Observation on [DATE] at 1:26 P.M. showed the resident in bed with side rails up. Observation on 3/12/20 at 12:00 P.M. showed the resident in bed with side rails up. During an interview on 3/13/20 at 9:55 A.M., the Minimum Data Set (MDS; a federally mandated assessment to be completed by the facility staff ) Coordinator said she would expect there to be a care plan for both a physical restraint and mobility/therapy. Record review of the facility's Care Plan policy, revised 7/07/19, showed: - The nursing staff, in coordination with other resident care services, develops and maintains a care plan for each resident; - This plan is developed in coordination with the attending physician's plan of medical care and is reviewed, as necessary, but at least quarterly, by all professional personnel involved in the care of the resident. |
| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>Based on interview and record review, the facility failed to revise and update comprehensive care plans with specific interventions to meet the individual needs of three residents (Resident #14, #42, and #51) out of 20 sampled residents. The facility's census was 99. 1. Record review of Resident #14's physician's orders [REDACTED].-harm or harm to others); - May use wheelchair when weak/unsteady gait. Record review of the resident's nurse's notes showed: - On 10/1/19, resident yelling found sitting in floor next to bed, skin tears to right forearm times four; - On 10/13/19, resident laying his/her back with cut to left eyebrow; - On 11/19/19, found resident in floor next to bed sitting on buttock, skin tear on right hand and wrist. Record review of the resident's comprehensive care plan, reviewed/revised 12/18/19, showed no new interventions for falls on 10/1/19, 10/13/19, or 11/19/19. Record review of the facility's policy titled, Fall Review, revision date 12/10/18, showed: - To develop and implement a system to ensure appropriate review of all falls; - Nursing staff shall assess and document for 72 hours post fall; - Falls shall be review in the daily Department Head Meeting; - Fall Review shall include: Care plan update. 2. Record review of Resident #42's Wound Evaluation Sheet showed: - On 1/30/20, left heel healed; - On 2/7/20, left heel healed; - On 2/13/20, left heel healed; - On 2/20/20, left heel healed; - On [DATE], left heel healed. Record review of the resident's nurse's notes showed: - On 2/7/20, documentation that heel remains healed; - On [DATE], documentation that area is healed. Record review of the resident's care plan, last revised 11/26/19, showed: - Black necrotic tissue (dead tissue) noted to left heel; - New order for skin prep twice daily; - No documentation of when the heel was healed. Observation on 3/12/20 at 1:37 P.M. showed the resident's heel did not have a wound. 3. Record review of Resident #51's POS, dated [DATE] through 3/31/20, showed: - [DIAGNOSES REDACTED]. moderate [MEDICAL CONDITION] affective disorder (a mental health condition that causes extreme mood swings that include emotional |

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

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| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>highs (mania or hypomania) and lows (depression); - Order for wheelchair when weak or unsteady gait. Record review of the resident's nurse's notes showed: - On 12/21/19, resident found laying on floor at doorway, when asked he/she states he/she was trying to plug in phone behind bed and lost balance. Did not hit head, landed on bottom. Assessment full range of motion (ROM) denies any injuries at this time. Call placed to guardian, unable to get through with four attempts. Hospice notified physician no redness or marks noted. Vital Signs, blood pressure 130/70, pulse 70, [MED]gen saturation 93% on room air; - On 2/14/20, shows resident complaints (c/o) pain in lower back/sacrum area from fall in room. Noted bruised area/[MEDICAL CONDITION]. Hospice aware and agrees to x-ray sacrum/coccyx area. Guardian informed, x-ray company called; - On 2/18/20, shows resident found in floor next to bed, no injuries. Range of motion (ROM) to all extremities within normal limits (WNL), no c/o, assist to wheelchair, cleaned up then back to bed. Call light in reach, [MED]gen put on resident, blood pressure 110/82, pulse 68, respirations 20, Oxygen saturation 88% room air, will continue to monitor. X-ray results from 2/14/20 negative for fracture. MD notified of fall. Guardian notified, hospice here and bed bath given. Oxygen at 2 liters (L), resident continues to take it off, call light in reach. Record review of the resident's comprehensive care plan showed last reviewed/revised on 2/2/20 did not contain new interventions for falls on 12/21/19, 2/14/20, and 2/18/20. 4. During an interview on 3/13/20 at 9:55 A.M., the Minimum Data Set (MDS; a federally mandated assessment instrument completed by the facility) Coordinator said she would except the care plan to be updated with new interventions when there is a fall and when a wound is healed. |
| F 0693<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to ensure correct procedures were followed when a feeding was administered through a Gastrostomy Tube ([DEVICE]; a tube inserted through the abdomen and used to deliver nutrition directly to the stomach) for one resident (Resident #71) out of 20 sampled residents. The facility's census was 99. Record review of the facility's policy titled, Bolus Gastric Tube Feedings, revised 07/07/19, showed: - Verify physician's orders [REDACTED]. the feeding; - Add prescribed amount of water to flush tube after the feeding is complete. Record review of Resident #71's physician's orders [REDACTED]. An observation on 3/12/20 at 11:56 A.M. showed: - Licensed Practical Nurse (LPN) A flushed [DEVICE] with 100 ml of water; - LPN A administered [MEDICATION NAME] through [DEVICE]; -<br>LPN A flushed G- Tube with 100 ml water; - LPN A did not check residual prior to administering [MEDICATION NAME]. During an interview on 3/12/20 at 12:00 P.M., LPN A said she/he should have checked for residual. During an interview on 3/13/20 at 9:55 A.M., the Assistant Director of Nursing (ADON) said she would expect nurses to check residual before administering medication or nutrition through a [DEVICE]. |
| F 0883<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement policies and procedures for flu and pneumonia vaccinations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to provide information and education to each resident or the resident's representative of the pneumococcal vaccines for three residents, (Residents #38, #62, and #96) and for one (Resident #62) for the influenza immunization. The facility failed to document pneumococcal vaccination history for one resident (Resident #38) of 5 sampled residents. This deficient practice had the potential to affect all residents. The facility's census was 99. 1. Record review of the United States Department of Health and Human Services Centers for Disease Control (CDC) Pneumococcal Vaccine Timing for Adults, dated 11/30/15, showed the following: - Pneumococcal disease in older adults are at greatest risk of serious illness and death; - CDC recommends two pneumococcal vaccines for adults: 13-valent pneumococcal conjugate vaccine (PCV 13, Prevnar 13) and 23-valent pneumococcal vaccine (PPSV 23, [MEDICATION NAME] 23); -<br>CDC recommends vaccination with PCV 13 for all adults [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions: - CDC recommends vaccination with PPSV 23 for all adults [AGE] years or older and adults 19 through [AGE] years old with certain medical conditions. Record review of the CDC Vaccine Information Statements (VISs), dated 8/15/19, recommends everyone six months of age and older get vaccinated every flu season. Record review of the facility's policy titled, Flu Vaccine/Pneumovac Vaccine, dated 9/20/07, showed: - All residents admitted to the facility shall receive(d) a screening as to date of last flu and or pneumonia vaccine; - Flu and/or pneumonia vaccines shall be offered to all resident of the facility unless contraindicated (Flu annually, pneumonia every five years); - Vaccines shall be recorded in the medical record in order to track recent administrations; - Residents and/or legal representatives shall be educated on the benefits and risks of each vaccine. 2. Record review of Resident #38's medical record showed: - The resident admitted on [DATE]; - The resident [AGE] years old; - The resident has a legal guardian; - [DIAGNOSES REDACTED]. 13 or PPSV 23. 3. Record review of Resident #62's medical record showed: - The resident admitted on [DATE]; - The resident [AGE] years old; - The resident has a legal guardian; - [DIAGNOSES REDACTED]. the influenza vaccine. 4. Record review of Resident #96's medical record showed: - The resident admitted on [DATE]; - The resident [AGE] years old; - The resident has a legal guardian; - [DIAGNOSES REDACTED]. 5. During an interview on 3/12/20 at 12:26 P.M., the Registered Nurse (RN) Educator said the facility sends the vaccination sheet and notification that the resident refused the pneumonia or other vaccine to the guardian. They document on the Treatment Administration Record (TAR) that the resident refused, they do not document that the sheet was sent to the guardian. |