STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265108	A. Building B. Wing	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to provide care in a manner that enhanced resident dignity for two residents (Residents #81, and Resident # 299), in a review of 20 sampled residents. The facility had four residents with urinary catheters. Facility staff failed to cover the residents' urinary catheter (tube leading from the urinary bladder to the outside to drain urine) drainage bags with a dignity/privacy bag. The facility census was 99. 1. Review of the facility provided Resident Rights, undated, showed the following: -As a resident of the facility, you have the right to a dignified existence and to communicate with individuals and representatives of choice. The facility will protect and promote your rights; -The facility will treat you with dignity and respect in full recognition of your individuality. 2. Review of Resident #81's care plan information, dated 8/6/18, showed the following: -The resident required total assistance from staff; -The resident will be able to maintain his/her dignity; -Staff was to assure the resident's dignity was maintained; -Alteration in elimination related to supra pubic urinary catheter related to bulbous urethral stricture (a narrowing of the canal that carries urine from the bladder). Review of the resident's physician's orders, dated September 2019, showed the resident had a urinary catheter. Observation on 9/9/19 at 11:04 A.M., showed the following: -The resident lay in his/her bed, on his/her right side, facing away from the open door; -The catheter drainage bag, containing urine, hung to the side of the bed that faced the open door and was visible from the hall as staff and residents passed by; (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The catheter drainage bag was not contained within a privacy bag. Observation on 9/10/19 at 8:57 A.M., showed the following: -The door to the resident's room was open and the privacy curtain was pushed up against the wall, making the resident visible from the hallway; -The resident lay in his/her bed, on his/her back; -The catheter drainage bag, containing urine, hung to the side of the bed that faced the open door and was visible from the hall as staff and residents passed by; -The resident's roommate sat in his/her wheelchair in the room; -The catheter drainage bag was not contained within a privacy bag. Observation on 9/10/19 at 10:43 A.M., showed the following: -The door to the resident's room was open and the privacy curtain was pushed up against the wall, making the resident visible from the hallway; -The resident lay in his/her bed, on his/her right side, facing away from the open door; -The catheter drainage bag, containing urine, hung to the wall side of the bed and was not visible from the hall; - The catheter drainage bag was not contained within a privacy bag; -Certified Nurse Assistant (CNA) F and CNA K entered the resident room and performed personal cares; -When the cares were complete, CNA F and CNA K positioned the resident on his/her left side; -CNA K placed the resident's catheter drainage bag, containing urine, towards the door side of the bed; -The catheter drainage bag was not contained within a privacy bag; -CNA F and CNA K left the resident's room, the privacy curtain pushed up against the wall, making the resident and his/her catheter drainage bag, containing urine, visible from the hall as staff and residents passed by. Observation on 9/11/19 at 6:00 A.M. and 8:55 A.M., showed the following: -The door to the resident's room was open and the privacy curtain was pushed up against the wall, making the resident visible from the hallway; -The resident lay in his/her bed, on his/her back; (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The catheter drainage bag, containing urine, hung to the side of the bed that faced the open door and was visible from the hall; -The catheter drainage bag was not contained within a privacy bag. Observation on 9/12/19 at 8:28 A.M., showed the following: -The resident lay in his/her bed, on his/her left side, facing the open door; -The catheter drainage bag, containing urine, hung to the side of the bed that faced the open door and was visible from the hall as staff and residents passed by; -The catheter drainage bag was not contained within a privacy bag. During interview on 9/10/19 at 11:05 A.M., CNA F said the following: -Catheter drainage bags were to be in a privacy bags if a resident were out of their room; -Resident #81 was rarely out of his room, so he/she did not have a privacy bag. 3. Review of Resident #299's baseline care plan dated 9/5/19 showed the following: -Mental attitude: oriented; -Activities of Daily Living (ADLs): urine-assist; -Catheter: blank. Observation on 9/9/19 at 5:18 P.M. in the resident's room showed the following: -The resident lay in bed; -The catheter drainage bag, containing dark yellow urine, hung to the side of the bed that faced the open door and was visible from the hallway; -The catheter drainage bag was not contained within a privacy bag. Observation on 9/10/19 at 8:46 A.M. in the resident's room showed the following: -The resident lay in bed; -The catheter drainage bag, containing dark yellow-orange urine, hung to the side of the bed that faced the open door and was visible from the hallway; -The catheter drainage bag was not contained within a privacy bag. Review of the resident's admission MDS dated [DATE] showed the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Severely impairedcognitionn; -Indwelling catheter; -Diagnoses of cancer, hypertension, and arthritis. Observation on 9/11/19 at 6:04 A.M., 7:27 A.M. and 3:15 P.M. in the resident's room showed the following: -The resident lay in bed; -The catheter drainage bag, containing tea-colored urine, hung to the side of the bed that faced the open door and was visible from the hallway; -The catheter drainage bag was not contained within a privacy bag. Observation on 9/12/19 at 8:37 A.M. in the resident's room showed the following: -The resident lay in bed; -The catheter drainage bag, containing tea-colored urine, hung to the side of the bed that faced the open door and was visible from the hallway; -The catheter drainage bag was not contained within a privacy bag. 4. During interview on 9/12/19 at 2:43 P.M. Licensed Practical Nurse (LPN) O said the following: -Catheter drainage bags should be in a dignity bag with the resident is out of the room in the wheelchair; -No dignity bag was needed in the room because the resident was in their room. During interview on 9/12/19 at 4:51 P.M., the Director of Nursing said he would expect the catheter drainage bag to always be kept in a privacy bag, but mainly when the resident is out of his/her room and at the resident's preference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 36219 Based on interview and record review, the facility failed to ensure one resident (Resident #96), in a review of twenty sampled residents, remained free from abuse when Licensed Practical Nurse (LPN) A said he/she would duct tape the resident to the bed, would drill the resident if he/she hit him/her, and would get a shot to knock the resident out. The facility's census was 99. 1. Review of the facility's Resident Rights, undated, showed residents have the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment and involuntary seclusion. Review of the facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy, undated, showed the following: -It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom of corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The term abuse (abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation) will be used throughout this policy unless specifically indicated; -An Administrator, licensed nurse, employee, or volunteer of a nursing home shall not physically, mentally, or emotionally abuse, mistreat or neglect a resident. -Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again; -Mental abuse includes but is not limited to humiliation, harassment, threats of punishment or deprivation. 2. Record review of Resident #96's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 8/6/19, showed the following: -Moderately impaired for daily decision making; -No signs or symptoms of psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality; -No behaviors; (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Rejected care (e.g.,blood workk, taking medications, activities of daily living (ADL) assistance) one to three days; -Wandered (walk or move in a leisurely, casual, or aimless way) one to three days; -Independent with bed mobility, transfers, ambulating in room, dressing, eating, toileting, and bathing; -Active diagnosis included: Debility (physical weakness, especially as a result of illness), atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), respiratory failure (results from inadequate gas exchange by the respiratory system), psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality). Record review of the resident's care plan, dated as initiated 8/9/19, showed the following: -Focus: Psychotropic medication related to diagnosis ofpsychosiss; -Interventions: If behaviors are present always attempt to rule out medical or environmental stimuli that could be a causative factor. If resident seems anxious or fearful provide positive touch by holding his/her hand and offering reassurance. Monitor for potential side effects as stated on the behavior interventions monthly flow record and keep physician informed. Record review of the facility's investigation, showed the following: -The Director of Nursing (DON) received statements on the morning of 8/22/19 that during the evening the night before on 8/21/19 that they had a resident, Resident #96, who was being combative and not easily redirected. In the process of staff attempting to redirect, it was stated that the nurse Licensed Practical Nurse (LPN) A said that if the resident didn't lay down in bed he/she would duct tape him/her to the bed, the resident threatened to hit LPN A and LPN A said if he/she did then he/she would drill him/her back if he/she did; -Resident #96 earlier in the evening had been noted to be easily agitated and more difficult to be redirected. The the resident had been sitting in a recliner in the core area and was attempting to get up; the leg rest was elevated and when attempting to get up the resident had one leg on each side of the leg rest. Staff attempted to explain the need to sit down and put legs up on leg rest so that they could put the leg rest down so he/she could walk. Staff were finally able to get the leg rest down and get the resident to walk, gait has been very unsteady and had been falling, staff needed to assist with ambulation and had placed a gait belt around him/her and he/she was still being agitated. The nurse had also given an as needed Ambien (sedative) and had obtained a one time order for Ativan (sedative) 2 milligram (mg). The nurse was concerned about increased fall risk and so they walked around core towards his/her room so that he/she might lay down. While the nurse was trying to encourage the resident to lay in bed, he/she did admit to saying that if the resident did not lay down he/she would duct tape him/her to the bed; -When LPN A was asked about this he/she said he/she did say this. LPN A said, I would never actually do this, I was just trying to get him to lie down. During an interview on 9/4/19 at 10:05 P.M., Certified Nurse Aide (CNA) C said the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She heard LPN A tell the resident two or three times that he/she would duct tape him/her to the bed; -He/She took the statement duct tape you to the bed' as a threat and considered it verbal abuse; -He/She heard LPN A also tell the resident that he/she would get a shot and knock him/her out and he/she felt that was a threat as well. Record review of CNA C's facility acquired written statement, dated 8/21/19, showed the following: -He/She was in checking on the resident when the resident stood up out of bed and told him/her to get out of the room or he/she would shoot him/her, then he/she took a swing at CNA C; -When CNA C heard the doors open/close he/she hollered for help and CNA B came into the room and then went to get more help; -CNA B, CNA D, CNA E, and LPN A came into the room and the resident took a swing at LPN A; -LPN A told the resident to not hit people and the resident took another swing at LPN A; -LPN A told the resident that he/she would go get some duct tape and tape him/her to the bed if he/she did not stop hitting and calm down. LPN A told the resident this two or three times. During an interview on 9/4/19 at 10:12 P.M., CNA D, said the following: -He/She heard LPN A tell the resident that he/she would duct tape him/her to the bed; -He/She saw the resident take a swing at LPN A and LPN A told the resident that if he/she hit him/her that he/she would drill the resident; -He/She took both statements duct tape you to the bed and drill you as threats and abuse. Record review of CNA D's facility acquired written statement, dated 8/21/19, showed the following: -He/She went to the special care unit with CNA E to help with the resident; -The resident was in his/her room with CNA B, CNA C, and LPN A; -LPN A was demanding the resident lay down, he/she said if the resident did not lay down then he/she would duct tape the resident to the bed; -The resident refused to lay down; -The resident threatened to hit LPN A; -LPN A told the resident that if the resident hit him/her then he/she would drill him/her back. During an interview on 9/10/19 at 3:20 P.M., CNA E said the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She went to the special care unit to help with the resident; -The resident was being combative; -LPN A came into the resident's room demanding the resident lay down or that he/she would get duct tape and tape him/her in the bed; -The resident threatened to hit LPN A and LPN A told him to go ahead and that if he/she did, then he/she would drill you right back; -LPN A also told the resident that if he/she didn't get in bed that he/she would get a shot ordered to knock his/her lights out; -He/she took all the statements as threats and abuse; -This was all witnessed by CNA B, CNA C, and CNA D. Record review of CNA E's facility acquired written statement, dated 8/21/19, showed the following: -He/She went to the special care unit to help with the resident; -The resident was being combative; -LPN A came into the resident's room demanding the resident lay down or that he/she would get duct tape and tape him/her in the bed; -The resident threatened to hit LPN A and LPN A told him to go ahead and that if he/she did then he/she would drill you right back; -LPN A also told the resident that if he/she didn't get in bed that he/she would get a shot ordered to knock his/her lights out; -This was all witnessed by CNA B, CNA C, and CNA D. During an interview on 9/3/19 at 10:00 P.M., CNA B said the following: -He/She heard LPN A tell the resident that he/she would duct tape him/her to the bed and drill him/her; -He/She took LPN A's statements duct tape you to the bed and drill you as a threat to the resident and felt they were verbal abuse; -He/She reported the incidents to LPN R. Record review of CNA B's facility acquired written statement, dated 8/21/19, showed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She heard staff member CNA C yelling for help and was in the resident's room. She went in and CNA C said that the resident had hit him/her in the jaw and cheek, so CNA B went and informed LPN A of the incident; -LPN A came into the resident's room and got between CNA C and the resident. LPN A told the resident to not hit and that he/she would duct tape him/her to the bed and drill him/her. During an interview on 9/4/19 at 6:41 P.M., LPN R, said the following: -It was reported to him/her on 8/21/19 that LPN A had threatened to duct tape the resident in his/her bed, had threatened to drill the resident if he/she hit LPN A, and had threatened to give the resident a shot to knock his/her lights out if the resident didn't get in bed and stay. It was reported to him/her as verbal abuse. Record review of LPN's facilityacquiredd written statement, dated 8/23/19, showed the following: -Once they got the resident to his/her room he/she did sit down on the edge of the bed, he/she refused to lay down; -The resident continued to slap, hit, and strike him/her and the aide; -At this time LPN A told the resident to settle down or he/she would duct tape him in bed. During an interview on 9/11/19 at 8:20 A.M., LPN A, said the following: -The resident had been agitated and verbally aggressive that day; -He/She said that he/she did say to the resident, Am I going to have to get duct tape and tape you in bed?. During an interview on 9/12/19 at 5:23 P.M., the administrator said the following: -He would not consider the statement duct taping the resident to the bed as a threat; -He would possibly consider it a threat if the resident threatened to hit the nurse and the nurse responded with if he/she did hit then he/she would drill the resident. MO159821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 36219 Based on observation, interview, and record review the facility failed to report an allegation of verbal abuse for one resident (Resident #96) in a review of 20 sampled residents. The facility census was 99. 1. Review of the facility's Abuse, Neglect, Mistreatment and Misappropriation of Resident Property Policy, undated, showed the following: -It is the policy of the facility to encourage and support all residents, staff, families, visitors, volunteers, and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom of corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. The term abuse (abuse, neglect, exploitation, involuntary seclusion, or misappropriation of resident property from abuse, neglect, misappropriation of resident property, and exploitation) will be used throughout this policy unless specifically indicated; -An Administrator, licensed nurse, employee, or volunteer of a nursing home shall not physically, mentally, or emotionally abuse, mistreat or neglect a resident. Any nursing home employee or volunteer who becomes aware of abuse, mistreatment, neglect, exploitation or misappropriation shall immediately report to the nursing home administrator; -The nursing home administrator or designee will report abuse to the state agency per state and federal requirements; -Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging andderogatoryy terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again; -Mental abuse includes but is not limited to humiliation, harassment, threats of punishment or deprivation; -Injuries of Unknown Origin: An injury should be classified as an injury of unknown source when both of the following conditions are met: 1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; 2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Immediately: means as soon as possible, but ought not to exceed 24 hours after discovery of the incident. *Immediately for the purposes of reporting a crime resulting in serious bodily injury meanscoveredd individual shall report immediately, but not more than two hours after forming the suspicion; -Reporting: It is the policy of the facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the administrator of thefaciltyy and to other officials including to the State Survey Agency in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility; -Internal reporting: Employees must always report any abuse or suspicion of abuse immediately to the administrator. **Note: Failure to report can make employee just as responsible for the abuse in accordance with State Law. The administrator will involve key leadership personnel as necessary to assist with reporting, investigation, and follow up. The administrator will report to the Medical Director; -External Reporting: Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located, any reasonable suspicion of a crime against any individual who is a resident of or is receiving care from the facility, and each covered individual shall report immediately, but not more than two hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. 2. Record review of the facility's investigation, showed the following: -The Director of Nursing (DON) received statements on the morning of 8/22/19 that during the evening the night before (8/21/19), Resident #96 was being combative and not easily redirected. In the process of staff attempting to redirect, Licensed Practical Nurse (LPN) A told the resident if he/she didn't lay down in bed he/she would duct tape the resident to the bed. The resident threatened to hit LPN A and LPN A said if the resident hit him/her, he/she would drill him/her back. During an interview on 9/4/19 at 10:05 P.M., Certified Nurse Aide (CNA) C, said the following: -He/she provided a written statement to the facility; -He/She heard LPN A tell the resident two or three times that he/she would duct tape him/her to the bed; -He/She took the statement duct tape you to the bed' as a threat and considered it verbal abuse; -He/She heard LPN A also tell the resident that he/she would get a shot and knock him/her out and he/she felt that was a threat as well; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She reported the incident to another co-worker. During an interview on 9/4/19 at 10:12 P.M., CNA D, said the following: -He/She heard LPN A tell the resident that he/she would duct tape him/her to the bed; He/Shee saw the resident take a swing at LPN A and LPN A told the resident that if he/she hit him/her that he/she would drill the resident' -He/She took both statements duct tape you to the bed and drill you as threats and abuse; -He/She reported incident to LPN R. During an interview on 9/10/19 at 3:20 P.M., CNA E, said the following: -The resident was being combative; -LPN A came into the resident's room demanding him/her to lay down or that he/she would get duct tape and tape the resident in the bed; -The resident threatened to hit LPN A and LPN A told him to go ahead and that if he/she did then he/she would drill you right back; -LPN A also told the resident that if he/she didn't get in bed that he/she would get a shot ordered to knock his/her lights out; -He/she took all the statements as threats and abuse; -He/She reported the incident to LPN R; -This was all witnessed by CNA B, CNA C, and CNA D. During an interview on 9/3/19 at 10:00 P.M., CNA B said the following: -He/She heard LPN A tell the resident that he/she would duct tape him/her to the bed and drill him/her; -He/She took the statements duct tape you to the bed and drill you as a threat to the resident and felt they were verbal abuse; -He/She reported the incidents to LPN R. During an interview on 9/4/19 at 6:41 P.M., LPN R, said the following: -It was reported to him/her on 8/21/19 that LPN A had threatened to duct tape the resident in his/her bed, had threatened to drill the resident if he/she hit LPN A, and had threatened to get the resident a shot to knock his/her lights out if the resident didn't get in bed and stay and it was reported to him/her as verbal abuse; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She went and got the keys from LPN A and had him/her work the other side of the building; -He/She reported what was reported to him/her to the DON on the morning of 8/22/19 when the DON arrived at the facility. During an interview on 9/12/19 at 4:52 P.M., the Director of Nursing (DON), said the following: -LPN R reported the incident to him, but did not report it as abuse; -He said staff never reported to him as abuse; -He did not feel that what LPN A said about duct taping the resident to the bed was a threat and did not consider it abuse; -He said LPN A denied saying that he/she would drill the resident if the resident hit him/her; -He denied knowledge that the LPN A threatened to get the resident a shot to knock him/her out; -He did not report it to the State Agency because he did not feel it was abuse. During an interview on 9/12/19 at 5:23 P.M., the Administrator said the following: -He would not consider the statement duct taping the resident to the bed as a threat; -He would possibly consider it a threat if the resident threatened to hit the nurse and the nurse responded with if he/she did hit then he/she would drill the resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 36219 41412 Based on observation, interview and record review, the facility failed to follow standards of practice and physician orders for two residents (Residents #59 and #81), in a review of 20 sampled residents, and for one additional resident (Residents #67) when staff did not follow physician orders, did not check for residual or placement of the resident's gastrostomy tube (G-tube; a tube inserted into the stomach that brings nutrition/medications directly into the stomach) before administering medications, did not administer the g-tube medications or fluids correctly and failed to obtain an apical (a pulse taken at the area of the apex of the heart at the point of maximum impulse) pulse prior to administering Digoxin (a medication used to treat heart failure and heart rhythm problems). The facility census was 99. 1. Review of the on-line Enteral Nutrition Practice Recommendations, a comprehensive guide developed by an interdisciplinary task force in 2009, showed: -If the resident has a continuous feeding, shut off the pump and clamp the tube; -Check placement by auscultating the resident's abdomen about 3 inches below the sternum with the stethoscope; gently insert 10 cc of air into the tube. You should hear the bubble entering the stomach; -If you hear this sound, gently draw back on the piston of the syringe. The appearance of gastric content implies that the tube is patent and in the stomach; -If no gastric content appears, the tube may be against the lining of the stomach or the tube may be obstructed; -If you meet resistance as you aspirate for stomach content, stop the procedure. Notify the nurse promptly; -After you establish that the tube is patent and in the correct position, clamp or kink the tube; -Reattach the syringe, without the piston, to the end of the tube and open the clamp or unkink the tubing; -Flush the tube with approximately 30ccs water; -Administer the medication(s); flush with 30 ccs of water after the final medication is administered; -Do not force any medication or fluid into the tube. Allow gravity to work as possible; -Deliver the medication slowly and steadily; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If the medication doesn't flow properly, don't force it. It may be too thick to flow through the tube; -If so, dilute it with water, being careful not to overload the resident with too much fluid; -If you suspect the tube placement is inhibiting the flow, stop the procedure and re-evaluate placement of the tube. -When the water has instilled, quickly clamp or kink the tube. Following medication/flush administration, reconnect tubing and turn on pump, if applicable; -Recap: Be sure and check for G-Tube placement prior to administering medications and flush the G-Tube after checking for placement, and before any medications are administered. 2. Review of Resident #81's face sheet showed the resident's diagnoses included: -Gastrostomy (procedure in which a tube is placed into the stomach for nutritional support as well as medication administration); -Gastro-esophageal reflux disease (GERD) without esophagitis (stomach contents leak back into the esophagus (food pipe)). Review of the resident's care plan, last revision on 6/22/18, showed: -The resident required tube feeding related to cerebrovascular accident (CVA) (stroke) with aphasia (inability to swallow); -Check for tube placement and gastric contents/residual volume per facility protocol/physician order and record. Review of the resident's September 2019 POS showed orders for: -Reglan (stomach and esophageal problems) 5 milligrams (mg) via tube four times daily; -Osmolite 1.2 calorie via tube at 60 milliliters (ml)/hour (hr) continuously; -Flush G-tube with 300 ml of water every six hours. Observation on 9/11/19 at 6:00 A.M., showed: -Licensed Practical Nurse (LPN) A prepared the resident's Reglan medication; -LPN A stopped the continuous tube feeding, disconnected the tube feeding and held it in his/her gloved hand; -LPN A attached a syringe to the g-tube and pulled back on the plunger; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN A visibly pulled the plunger back with force and was only able to move the plunger approximately 5 ml (no residual was obtained); -LPN A removed the syringe, removing the plunger, and reattached the syringe to the g-tube; -LPN A added 120 ml of water to the syringe from a drinking cup, and while the syringe was still holding the water that was not visibly instilling or moving through the tube, added the prepared medication; -LPN A did not check for tube placement prior; -LPN A held the g-tube and attached syringe up in the air and the syringe contents did not flow through the tube; -LPN A attached the plunger to the syringe and forcefully pushed the plunger downward, making the syringe contents move through the tube; -LPN A removed the syringe from the g-tube, removed the plunger and reattached the syringe to the g-tube; -LPN A added 120 ml to the syringe, placed the plunger in the syringe and pushing down on the plunger, pushed the fluid through the tube; -LPN A disconnected the syringe from the g-tube and reconnected the continuous feeding, restarting the pump; -LPN A did not flush the resident's g-tube with 300 ml of water. During interview on 9/11/19 at 6:14 A.M., LPN A said: -He/She had never used a stethoscope to check for placement of g-tubes prior to medication administration; -He/She had tried to get residual but the plunger of the syringe just would not pull back; -Sometimes the resident's g-tube would get clogged and he/she would have to push, sometimes using force, to get the fluids or medications to go through the tube instead of letting it run in via gravity; -He/she did not realize he/she was to flush the resident's g-tube with 300 ml of water; he/she had only given the resident 240 ml of water. 3. Review of Resident #59's face sheet showed the resident's diagnoses included: -Dysphagia (difficulty swallowing) -Protein-calorie malnutrition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's August 2019 POS showed: -Jevity 1.5 calories, 240 ml via tube three times daily; -Pureed textured diet with thin liquids. Review of the resident's care plan, last revision on 8/29/19, showed: -The resident was at nutritional risk related to his/her diagnoses of dementia, heart failure, diabetes, chronic obstructive pulmonary disease (COPD)lung disorderr), dysphagia, poor appetite and significant weight loss; -Provide enteral feedings as ordered; -Resident to be up in his/her wheelchair for all meals to help prevent choking/aspiration; -Encourage consumption of diet as ordered by physician. Review of the resident's physician 8/29/19 progress note, dated 8/29/19 showed orders to discontinue feedings during day due to the resident having complaints of feeling full and unable to eat his/her meals. Review of the resident's September 2019 POS showed: -Jevity 1.5 calories at 75 ml/hr for 10 hours from 7:00 P.M. to 5:00 A.M.; -Pureed textured diet with thin liquids. Observation on 9/11/19 at 6:27 A.M. showed the resident resting quietly in bed, his/her Jevity feeding infusing at 75ml/hr. Observation on 9/11/19 at 7:04 A.M. showed the resident resting quietly in bed, his/her Jevity feeding infusing at 75ml/hr. Observation on 9/11/19 at 7:43 A.M. showed: -The resident resting quietly in bed, his/her Jevity feeding infusing at 75ml/hr; -CNA P entered the resident's room with his/her breakfast tray, offering the resident the meal; -The resident said he/she did not want the meal; -CNA P left the resident room and placed the resident meal tray back on the hot cart at the nursing desk. Observation on 9/11/19 at 8:16 A.M. showed: -The resident resting quietly in bed, his/her Jevity feeding infusing at 75ml/hr; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-LPN O entered the resident's room and stopped the resident's feeding. During interview on 9/11/19 at 7:50 A.M., the resident said he/she felt full and was not hungry. During interview on 9/11/19 at 7:45 A.M., CNA P said the resident refused breakfast and told him/her his/her stomach felt full. During interview on 9/11/19 at 8:20 A.M., LPN O said: -The resident's feeding was complete; -The night nurse was to stop the feeding at 5:00 A.M. but had not. 4. Review of Drugs.com showed a health professional should check an apical pulse (a measure of cardiac function that is completed by placing a stethoscope at the apex of the heart and counting for one minute), prior to giving digoxin. Digoxin will lower the heart rate. The beginning of toxicity could be a rate below 60 beats per minute. The healthcare professional would also listen for any skipped beats and abnormal rhythm changes. They would listen for a regularization of a previously irregular heart rate as well. If the heart rate falls below 60 bpm, the dose would be held and the physician called for further instructions. 5. Review of Resident #67's Physician Order Sheet (POS) for September 2019 showed an order for digoxin 125 micrograms (mcg) by mouth every other day. Hold for heart rate less than 60 beats per minute. Observation on 9/10/19 at 8:45 AM showed the following: -Registered Nurse (RN) N prepared the morning medications for Resident #67; -RN N attempted to obtain the resident's heart rate with a pulse oximeter on several of the resident's fingers but could not get a reading; -A Certified Nurse Aide (CNA) entered and obtained the resident's vital signs with an electronic blood pressure cuff; -The CNA reported to RN N the resident's heart rate was 67 beats per minute; -RN N administered digoxin 125 micrograms (mcg) by mouth every other day; -RN N did not obtain an apical pulse prior to administering the digoxin to the resident. During an interview on 9/10/19 at 3:33 PM RN N said he/she did not typically take a manual pulse unless the resident's heart rate was unusual for the resident or very low. RN N said he/she did not check an apical pulse prior to administering digoxin. During interview on 9/12/19 at 4:51 P.M., the Director of Nursing said the following:: -He expected staff to check G-tubes for placement prior to medication administration; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He expected staff to follow physicians' orders; -He expected staff to obtain an apical pulse prior to the administration of digoxin.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, the facility failed to ensure staff were trained and available to provide Cardiopulmonary Resuscitation (CPR) (the manual application of chest compressions and ventilations to persons in cardiac arrest, done in an effort to maintain viability until advanced help arrives) when transporting residents who requested to be full code, in the facility van. Five residents (Resident #27, #30, #16, #148, and #65) in a review of 20 sampled residents and five additional residents (Resident #21, #37, #58, #68, and #10) , who were a full code, were transported multiple times by a facility transporter who was not certified to perform CPR. The facility census was 99. 1. Review of the list of resident code status provided by the Director of Nursing (DON) dated [DATE] showed Residents #27, #30, #16, #148, #65, #21, #37, #58, #68 and #10 were full code. Review of the facility's transportation log dated [DATE] through [DATE] showed the Maintenance/Transporter II provided transportation of full code residents in the facility van as follows: -On [DATE] transported Resident #21 from the facility to a local physician appointment; -On [DATE] transported Resident #21 from the facility to a local cancer treatment center; -On [DATE] transported Resident #37 from the facility to a local physician appointment; -On [DATE] transported Resident #58 from the facility to a local cancer treatment center; -On [DATE] transported Resident #27 from the facility to a local physician appointment; -On [DATE] transported Resident #58 from the facility to a local physician appointment; -On [DATE] transported Resident #68 from the facility to a local physician appointment; -On [DATE] transported Resident #30 from the facility to a local physician appointment; -On [DATE] transported Resident #27 from the local hospital to the facility; -On [DATE] transported Resident #58 from the facility to a local physician appointment; -On [DATE] transported Resident #16 from the facility to a local physician appointment; -On [DATE] transported Resident #148 from the facility to a local physician appointment; -On [DATE] transported Resident #10 from the facility to a local physician appointment; -On [DATE] transported Resident #65 from the local hospital to the facility. Review of Maintenance/Transporter II's employee file showed the following: (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hired by the facility on [DATE]; -No documentation of current CPR certification. During interview on [DATE] at 1:50 P.M. Maintenance/Transporter II said the following: -He/She transports residents to appointments; -He/She does not know resident code status; -If a resident became unresponsive he/she would drive directly to the hospital; -If the transport wasn't in town he/she would call 911; -He/She does transport residents out of town, several miles away; -He/She was not CPR certified and does not know the guidelines to perform CPR; -Occasionally another staff member will go with him/her on transport; During interview on [DATE] at 4:20 P.M. and [DATE] at 4:52 P.M. the Director of Nursing (DON) said the following: -The facility did not have a transportation policy; -Maintenance/Transporter II is a new employee and is not CPR certified; -Maintenance/Transporter II transports residents to appointments; -He would expect facility staff to be CPR certified if transporting full code residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 41412 Based on observation, interview, and record review the facility failed to ensure staff provided four of 20 sampled residents (Resident #59 #71, #80 and #81) that were unable to do their own Activities of Daily Living (ADL's), the necessary care and services to maintain good personal hygiene and prevent body odor. The facility census was 99. 1. Review of the facility policy, titled Activities Of Daily Living Care, revised 9/2015 showed: -Purpose: To provide all residents of this facility with acceptable and dignified personal hygiene on a routine basis; -All residents will receive the necessary care and services to maintain good personal hygiene to prevent body odor; -All residents will receive a partial bath daily when not given a shower; -All residents will be given or assisted with adequate oral hygiene at least once daily and PRN; -All residents will be given or assisted with adequate nail care; -All residents will be assisted with passive range of motion at least daily during ADL care; -All residents will be encouraged to perform active range of motion (ROM) as tolerated; -All residents will be allowed to or be assisted with transfers; -All residents will be allowed to or be assisted with bed mobility; -All residents will be allowed to or be assisted with ambulation; -All residents will be allowed to or be assisted with dressing or grooming; -All residents will be allowed to or be assisted with eating; -All above activities of daily living care will be performed on a daily basis as needed. 2. Review of the Nurse Assistant in a Long Term Care Facility manual, Revision November 2001, showed the following: -Purposes of oral hygiene (mouth care): A clean mouth and properly functioning teeth are essential for physical and mental well-being of the resident, prevent infections in mouth, remove food particles and plaque, stimulate circulation of gums, eliminate bad taste in mouth, thus food is more appetizing; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Purposes of Nail Care: Decrease bacteria buildup under nail that could cause infections, give the resident a neat appearance, prevent cuts/scratches from long nails; -Clean nails daily; -Nail care should be done as needed for each resident; -Residents who are incontinent and confused should have their fingernails cut short so that feces do not collect under the nails; -Helps the resident feel well groomed; Shaving: -Evaluate the resident's need for shaving daily; -Let residents shave themselves if they are able to. Shaving is a good exercise. 3. Review of Resident #59's Annual Minimum Data Set (MDS) a federally mandated assessment instrument, completed by facility staff, dated 7/18/19 showed the following: -Severely impaired cognition; -Required extensive assistance of one staff member with personal hygiene; -Required extensive assistance of one staff member with toilet use; -Total dependence of one staff for bathing; -Always incontinent of bowel and bladder; -Rejection of care one to three times weekly; -No natural teeth. Review of the resident's care plan, revised on 7/25/19, showed: -Diagnoses included dementia, heart failure and chronic obstructive pulmonary disease (COPD) (lung disorder); -Impaired ADL and mobility performance related to multiple disease processes; -Encourage resident to complete oral care with morning and evening care as needed (has a full set of dentures but does not wear them); -Staff to provide good oral care daily and as needed; -Incontinent of bladder; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Cleanse skin after each episode of incontinence as needed. Review of the resident's September 2019 Physician Order Sheets (POS) showed orders for oral hygiene every two hours. Observation on 9/10/19 at 4:25 P.M. showed: -Certified Nurse Aide (CNA) L and CNA I entered the resident's room, washed their hands and donned gloves; -CNA L unfastened the resident's brief, soiled with urine and stool and tucked the front of the brief between the resident's legs; -CNA I turned the resident to his/her left side; -CNA L wiped the resident's anal area of feces with disposable wipes, removed the soiled disposable brief, placing it in a basket and tucked a clean incontinent brief under the resident; -CNA I rolled the resident to his/her right side and pulled the clean incontinent brief under the resident and positioned him/her on his/her back; -Both CNAs pulled the clean incontinent brief up through the resident's legs, covering his/her front genitalia, and fastened the side tabs; -Neither CNA cleansed the resident's frontal genitalia or groin; -CNA L and CNA I covered the resident up with a blanket and left the room; -Neither CNA offered or performed oral care for the resident; -The resident had dry lips and tongue. Observation on 9/11/19 at 9:30 A.M. showed: -CNA P and CNA Q entered the resident's room to prepare to get him/her up for the day; -CNA O unfastened the resident's brief saturated with urine and tucked the front of the brief between the resident's legs; -CNA P turned the resident to his/her left side; -CNA O removed the soiled disposable brief, folded it and put it in a basket; -CNA O tucked a clean disposable brief under the resident and rolled the resident to his/her right side; -CNA P pulled the clean incontinent brief under the resident and positioned him/her on his/her back; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Both CNAs pulled the clean incontinent brief up through the resident's legs, covering his/her front genitalia, and fastened the side tabs; -Neither CNA cleansed the resident's frontal genitalia, groin or buttocks of urine; -CNA P and CNA Q transferred the resident to his/her wheelchair with the lift; -Neither CNA offered or performed oral care for the resident and did not wash the resident's face or hands; -The resident had odorous breath, dry lips and tongue and dried yellow matter in the corner of each of his/her eyes. During interview on 9/10/19 at 4:42 P.M., both CNA L and CNA I said they had just forgotten to wash to resident's front peri area and had not thought to offer oral care for the resident. During interview on 9/11/19 at 9:50 A.M., CNA P said he/she was just in a hurry to get the resident up he/she had forgotten to clean the resident's peri area, wash his/her face and hands or provide oral care. During interview on 9/10/19 at 9:53 A.M., CNA Q said: -He/She knew he/she should have used the wipes or soap and water to clean the resident's peri-area, but neither CNA had gathered the supplies needed and were in a hurry to get the resident up for the day; -It was hard to get to the resident sink for soap and water, making it hard to wash the resident's face and hands; -He/She thought the licensed nurse provided the resident oral care because the resident was a swallow risk. During interview on 9/10/19 at 10:10A.M.M, Registered Nurse (RN) N said he/she sometimes performed the resident's oral care, but mostly he/she thought the CNA staff completed this. 4. Review of Resident #81's Quarterly MDS, dated [DATE] showed the following: -Severely impaired cognition; -Required total dependence of one staff member with toilet use, personal hygiene and bathing; -The resident had a suprapubic catheter; -Always incontinent of bowel; -No documentation of rejection of care; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Diagnoses included cerebral infarction (stroke), urinary tract infections, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body). Review of the resident's care plan, revised on 8/6/18, showed: -Required total assistance of staff; -Oral care with morning and evening care; -Required total assist of all ADLs; -Potential for dehydration; monitor for signs of dehydration such as dry cracked mucous membranes; -Incontinence care with every undergarment change and as needed; -The resident received enteral feedings. Review of the resident's September 2019 Physician Order Sheets (POS) showed orders for oral hygiene every two hours. Observation on 9/11/19 at 6:00 A.M. showed: -Licensed Practical Nurse (LPN) A entered the resident's room to perform cares; -The resident had stubble facial hair and his/her lips were dry and cracked and his/her tongue was dry with a white coating; -LPN A did not offer or perform oral care for the resident. Observation on 9/11/19 at 8:55 A.M. showed the resident's lips were dry and cracked and his/her tongue was dry with a white coating. Observation on 9/11/19 at 10:43 A.M. showed: -CNA F and CNA K entered the resident's room to prepare to give him/her morning care, including a bed bath; -The resident was on his/her right side in his/her bed; -The resident had stubble facial hair and his/her lips were dry and cracked and his/her tongue was dry with a white coating; -CNA K unfastened the resident's brief, soiled with feces, and tucked the front of the brief between the resident's legs; -CNA F turned the resident over more to his/her right side; -CNA K removed the soiled disposable brief, folded it and put it in a basket; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA K wiped the resident's anal area of feces with disposable wipes, removed his/her gloves, washed his/her hands with soap and water and donned another pair of gloves; -CNA K washed the resident's buttocks area with soap and water, separating the resident's genitalia from the groin skin folds, cleansing visible feces from the area; -CNA K tucked a clean disposable brief under the resident and rolled the resident to his/her left side; -CNA F pulled the clean incontinent brief under the resident and positioned him/her on his/her back; -Both CNAs pulled the clean incontinent brief up through the resident's legs, covering his/her front genitalia, and fastened the side tabs; -Neither CNA cleansed the resident's front genitalia; -Neither CNA offered or performed oral care for the resident; -Neither CNA offered or shaved the resident. During interview on 9/11/19 at 6:10 A.M., LPN A said: -CNA staff performed oral care and would complete that with morning rounds and their checks every two hours; -He/She did not think CNA staff shaved the resident; he/she thought because of his/her race, he/she required a barber for shaving to prevent skin issues. During interview on 9/11/19 at 11:10 A.M., CNA K said: -He/She knew complete peri-care included the cleansing and washing of all areas of the genitalia; -He/She must have just forgotten to wash the resident's front genitalia; -He/She did not provide any internal oral care; he/she did not think the resident was to have anything by mouth; -He/She had forgotten to bring the supplies for shaving into the resident room; During interview on 9/11/19 at 11:15 A.M., CNA F said he/she had not performed oral care for the resident because he/she was gathering the dirty supplies and thought CNA K was finishing that care. 4. Review of Resident #71's care plan revised 11/16/18 showed the following: -Impaired Activities of Daily Living (ADL) and mobility performance related to dementia, multiple disease process; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident is requiring extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene at this time. Encourage him/her to do as much for him/herself as possible; -If resident is rejecting care, staff to make sure he/she is safe and then leave for a few minutes then return and attempt to complete care again; -Oral care with A.M. and P.M. care and as needed (has own teeth, in poor condition, dentist aware, family does not want to pursue dental care at this time due to condition). Review of the resident's quarterly MDS dated [DATE] showed the following: -Short and long term memory problems; -No rejection of care; -Totally dependent on one staff for personal hygiene; -Diagnoses of dementia and depression. Observation on 9/9/19 at 10:46 A.M. in the resident's room showed the following: -The resident lay in bed with his/her eyes closed; -The resident's fingernails were long; -Brown-black debris was present under the resident's fingernails. Observation on 9/10/19 at 2:36 P.M. in the resident's room showed the following: -The resident sat in his/her wheelchair; -Brown-black debris was present under the resident's fingernails; -The resident's fingernails were long; -The resident's teeth were covered with a yellow film; -Dry brown debris was present on the resident's lips; -CNA DD and CNA P transferred the resident from wheelchair to bed and provided pericare; -CNA DD asked the resident if he/she could brush his/her teeth; -The resident said Yes; -CNA DD said He/She will never let me do it; -Staff did not provide nail care or oral care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 9/11/19 at 6:02 A.M. in the dining room showed the following: -The resident sat in his/her wheelchair; -Brown-black debris was present under the resident's fingernails; -The resident's fingernails were long. Observation on 9/11/19 at 9:15 A.M. in the shower room showed the following: -The resident lay on the shower gurney; -CNA DD and CNA P transferred the resident from the shower gurney to his/her wheelchair; -CNA DD said, I wish the resident would let us brush his/her teeth; -Brown-black debris was present under the resident's fingernails; -The resident's fingernails were long; -The resident's gums appeared red and a white buildup was present along the gumline; -CNA staff did not offer or provide oral care or nail care. Observation on 9/12/19 at 8:47 A.M. at the nurses' station showed the following: -The resident sat in his/her wheelchair; -The resident's fingernails were long with brown black debris under them; -The resident's teeth were covered with yellow debris, his/her gums were red and a white buildup was present along the gum line. During interview on 9/11/19 at 2:52 P.M. CNA P said the following: -The resident usually refuses to let staff do oral care; -The resident's teeth were bad; -Staff try to provide oral care but the resident screams or spits at staff; -The resident will not let staff do anything with his/her nails; -He/She has not provided any oral care or nail care for the resident today. During interview on 9/11/19 at 4:03 P.M. CNA HH said the following: -The resident is very contracted; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She can't and doesn't brush the resident's teeth, the resident's gums will bleed; -The resident won't let him/her do anything with his/her fingernails. 5. Review of Resident #80's admission MDS dated [DATE] showed the following: -Cognitively intact; -No rejection of care; -Required extensive assist of one staff member with personal hygiene; -Diagnoses of cancer and anemia. Review of the resident's care plan revised 7/21/19 showed the following: -Decline in ADL and mobility performance related to low endurance and weakness from recent hospital stay and multiple disease processes; -Set up care items and allow resident to do what he/she can do. Staff to complete as needed. Observation on 9/9/19 at 5:45 P.M. in the resident's room showed the following: -The resident sat in his/her wheelchair; -The resident had stubble facial hair. Observation on 9/10/19 at 10:04 A.M. in the resident's bathroom showed the following: -The resident sat on the toilet; -The resident had stubble facial hair. Observation on 9/12/19 at 8:54 A.M. in the resident's room showed the following: -The resident sat in his/her wheelchair; -The resident had stubble facial hair. During interview on 9/12/19 at 8:54 A.M. the resident said the following: -Staff tell him/her they will shave him/her but they never do it; -He/she has not been shaved this week. During interview on 9/12/19 at 2:43 P.M. LPN O said the following: -CNA staff should clean and trim resident nails unless the resident is diabetic; (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA staff should provide oral care daily and at bedtime; -If the resident rejects care it should be reported to the nurse; -Staff should shave those who need shaving daily and as requested. During interview on 9/12/19 at 4:51 P.M., the Director of Nursing said the following: -He expected staff to offer and perform oral care in the morning, evening and as needed n all residents; -He expected staff to shave residents at least on their shower days or to their preference.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility staff failed to notify the physician and re-evaluate interventions when a resident's wound deteriorated, stage a wound according to the National Pressure Ulcer Advisory Panel (NPUAP) guidelines, or use air mattresses according to manufacturer's instructions to prevent development or worsening of pressure ulcers for one resident (Resident #6) in a review of two sampled residents with pressure ulcers, resulting in deterioration of the wound from a suspected deep tissue injury (pressure injury with of persistent non-blanchable deep red, maroon, purple discoloration, skin can be intact or non-intact) to a Stage IV wound (full-thickness loss of skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer). The facility census was 97. Review of NPUAP guidelines, dated September 2016, showed the following definitions: -Stage I pressure injury is intact skin with localized area of non-blanchable (when you press on the area of redness the redness does not go away) erythema (redness). Presence of blanchable erythema changes in sensation, temperature, or firmness may precede visual changes; -Stage II pressure injury is a partial-thickness loss of skin with exposed dermis (the thick layer of living tissue below the top layer of skin that forms the true skin). The wound bed is viable, visible and deeper tissue are not visible. Granulation tissue (new connective tissue), slough (dead tissue in the process of separating from the body which is usually light colored, soft, moist, or stringy), and eschar (dead tissue that sheds or falls off from health skin) are not present; -Stage III pressure injury is a full thickness loss of skin, where adipose (fat) is visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough and eschar may be visible, but do not obscure the extent of tissue loss. The depth of tissue damage varies by the location on the body. Undermining and tunneling may occur. Fascia (a thin sheath of fibrous tissue), muscle, tendon, ligament, cartilage or bone are not exposed; -Stage IV pressure injury is a full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible, but do not obscure the extent of tissue loss. Rolled edges, undermining and or tunneling often occur. Depth varies by location; -Unstageable pressure injury is a full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar; -Deep Tissue Pressure Injury is an intact or non-intact skin with localized area of persistent non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (unstageable, Stage III or Stage IV pressure injury). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the Resident Assessment Instrument (RAI manual), dated 10/1/17, directed staff to code the Minimum Data Set (MDS) for Stage II pressure ulcers by definition as ulcers with partial-thickness loss of the dermis. Granulation tissue, slough or eschar are not present in Stage II pressure ulcers. Therefore, Stage II pressure ulcers should not be coded as having granulation, slough or eschar tissue. Review of the Manufacturer's Operator Manual, dated 2016, for the facility alternating pressure and low air loss mattress showed the following: -Pressure of the mattress is adjusted by choosing the patient's (resident's) corresponding weight setting using the weight setting buttons (+) or (-); -Follow the hand check procedure to ensure an appropriate pressure level. Review of the facility's Skin Integrity Management Program, undated, showed the following: -Residents' skin will be assessed by licensed personnel on admission; -Skin assessments will be conducted weekly; -Staff will be encouraged to report all skin changes to the charge nurse; -Staff instructed to report any reddened or open area to the charge nurse. 1. Review of Resident #6's admission Minimum Data Set (MDS), a federally mandated assessment assessment instrument completed by facility staff dated 9/6/19, showed the following: -Severe cognitive impairment; -Independent with bed mobility and eating; -Requires limited physical assistance with toilet use; -Not at risk to develop pressure ulcers; -No pressure ulcers present; -No pressure reducing device to bed or chair; -Weight 138 pounds (lbs.); -Occasionally incontinent of bladder; -Frequently incontinent of bowel. Review of the resident's care plan, dated 9/11/19, showed the following: -At risk for alteration in skin integrity; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Moisturize skin; -Do not massage bony prominences; -Weekly skin assessment; -Report red areas to the charge nurse. Review of the resident's skin assessment, dated 9/21/19, showed the resident with bruising to his/her forehead, right wrist, right foot, and edema to the right foot. The note did not describe any other skin changes. Review of the resident's nurses notes, dated 9/21/19, showed the following: -Dark area to inner right and left buttocks, from pressure; -Area is not currently open at this time; -Cream (Super Duper Diaper Doo, a barrier cream) applied per physician's order, -Requested an order for a Roho (pressure reducing wheelchair cushion) from the physician. Review of the resident's nurses notes dated 9/22/19, showed staff documented the buttocks remained dark red/purple. Review of the resident's nurses notes, dated 9/24/19, showed the following: -readmitted to facility on 9/20/19; -Stage I pressure ulcer to each buttock, area noted to be dark red/purple; -Stage I pressure ulcer to right buttock and two ulcers to left buttock; -Blood noted to be draining from all areas; -Requested change of treatment from the physician from Super Duper Diaper Doo to Lantiseptic (moisturizer to treat dry, rough skin and minor skin irritations); -Roho cushion placed on wheelchair and pressure relieving mattress placed on bed. Review of the resident's Wound/Pressure Sore Progress Record, dated 9/24/19, showed the following: -Right buttock Stage II pressure ulcer measures 2.3 centimeter (cm) in length, and 2.2 cm in width; -Left buttock (a) Stage II pressure ulcer measures 0.6 cm in length, and 0.5 cm in width; -Left buttock (b) Stage II pressure ulcer measures 2.6 cm in length, and 1.3 cm in width; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Small amount of bloody drainage noted to all wounds; -No documentation staff notified the physician the wounds had opened. Review of the resident's nurses notes, dated 9/27/19, showed staff documented the open area to the resident's buttock had sloughing skin to the wound bed. The note did not contain documentation of physician notification the wound had sloughing skin. (Slough would not be present in a Stage II wound.) Review of the resident's nurses notes, dated 9/28/19, showed staff documented the resident's bilateral buttock wound was beefy red with yellow sloughing skin. The resident complained of pain in his/her buttock. The note did not contain documentation of physician notification the wound was beefy red with yellow sloughing skin and pain. (Beefy red (granulation tissue) and slough would not be present in a Stage II wound.) Review of the resident's nurses notes, dated 9/29/19, showed staff documented the open areas on the resident's buttock wound bed as dark brown with pink peri wound. The note did not contain documentation of physician notification the wound bed was dark brown. Review of the resident's nurses notes, dated 10/2/19, showed the following: -The resident complains of pain/burning to buttocks; -Buttocks wound bed red with yellow slough present; -Some areas of white macerated (dead skin/tissue that turns white from moisture) tissue noted around wound edges. The note did not contain documentation of physician notification the wound had areas of macerated tissue around the wound edges. Review of the resident's nurses notes, dated 10/3/19, showed staff documented the buttocks wound bed pink with yellow thickened area to middle of the wound bed. Review of the resident's Wound/Pressure Sore Progress Record, dated 10/4/19, showed the following: -Right buttock Stage II pressure ulcer measures 5.2 cm in length, 3.1 cm in width, 0.1 cm in depth; -Left buttock (a) Stage II pressure ulcer measures 5.5 cm in length, and 2.7 cm in width, 0.1 cm in depth; -Small amount of serosanguinous (blood and the liquid part of blood that is clear to yellow) drainage noted to both wounds; -Wound deteriorating. Review of the resident's Nurses Notes, dated 10/4/19, showed staff documented extension of wound assessment: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Ulcer to left buttock and coccyx (tailbone) areas wound bed noted to have yellow/greenish slough present, slight odor present; -Ulcer to right buttock wound bed noted to have yellow/greenish slough present. The note did not contain documentation of physician notification the wound deteriorated, with yellow/greenish slough and odor present. Review of the resident's care plan, revised 10/9/19, showed the following: -Pressure ulcers to coccyx; -Assess, record, monitor wound healing weekly to include: a. measurements of length, width, and depth; b. assess and document status of perimeters; c. wound bed and healing progress; d. keep the physician informed; -Encourage assist with repositioning every two hours; -Monitor for signs and symptoms of infection and report to the physician: i.e. foul odor, purulent (consisting of pus) drainage, or elevation in temperature; -Weekly assessment by licensed nurse; -Pressure relieving mattress on bed, cushion in wheelchair; -Treatment as ordered by the physician. Review of the resident's Wound/Pressure Sore Progress Record, dated 10/11/19, showed the following: -Coccyx Stage II pressure ulcer measures 3.8 cm in length, 6.7 cm in width, and 0.1 cm depth; -White/gray non-viable tissue and/or non-adherent yellow slough; -Granulation tissue bright beefy red; -Small amount of bloody drainage noted to wound. Review of the resident's nurses notes, dated 10/11/19, showed the following: -Stage II pressure ulcer to coccyx/buttocks noted to have slight odor present; -Wound bed noted to have thick yellow slough present; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Granulation tissue noted around wound bed edges; -Requested physician change the treatment order from Lantiseptic to Silvadene (medication used to treat or prevent infection). The nurse's note did not contain documentation of physician notification the wound deteriorated, with white/gray non-viable tissue, and increased measurements. Review of the resident's Wound/Pressure Sore Progress Record, dated 10/18/19, showed the following: -Sacrum Stage II pressure ulcer measures 6.9 cm in length, 4.9 cm in width, and 0.2 cm depth; -White/gray non-viable tissue and/or non-adherent yellow slough; -Granulation tissue bright beefy red; -Small amount of foul purulent drainage noted to wound; -Wound deteriorating. Review of the resident's Nurses Notes, dated 10/18/19, showed the following: -Stage II pressure ulcer to coccyx/buttocks; -Dressing removed noted to be saturated with foul purulent drainage; -Wound bed noted to have dark grayish slough present, granulation tissue noted around wound bed edges; -A dark area above pressure ulcer noted and measures 1.4 cm x 1.4 cm; -Surgical consult set up; -Family notified of surgical consult. Review of the resident's significant change in status assessment (SCSA) MDS dated [DATE], showed the following: -Severe cognitive impairment; -Requires extensive physical assistance of two or more staff members with bed mobility, transfers, and toilet use; -At risk for developing pressure ulcers -One Stage II pressure ulcer present; -One unstageable pressure ulcer with suspected deep tissue injury in evolution; (continued on next page)

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	265108	A. Building B. Wing	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Weight 137 lbs.; -Frequently incontinent of bowel and bladder. Review of the resident's care plan, revised 10/18/19, showed staff to encourage the resident to lay in bed to relieve pressure to his/her buttocks. Review of the resident's physician note, dated 10/21/19, showed the following: -Sacral wound approximately 4 cm in length, and 3 cm in width; -Moderate amount of fibrinous slough over the surface; -Wet to dry dressings two times daily; -Imperative to keep the pressure off his/her coccyx at all times, so the wound can heal; -If the wound progresses his/her prognosis was very poor. Review of the resident's nurses notes, dated 10/24/19, showed the following: -Pressure ulcer to coccyx; -Moderate amount of purulent drainage with foul odor on dressing when removed; -Yellow slough present to wound bed, with wound edge noted to have granulation tissue; -Pressure ulcer located above coccyx to left buttock; -Wound bed is dark brown in color; -Wet to dry dressing placed. Review of the resident's Wound/Pressure Sore Progress Record, dated 10/24/19, showed the following: -Sacrum Stage II pressure ulcer measures 6.7 cm in length, 4.2 cm in width, and 0.2 cm depth; -Sacrum unstageable pressure ulcer measures 3.4 cm in length, 1.9 cm in width, -White/gray non-viable tissue and/or non-adherent yellow slough; -Granulation tissue pink &/dull, dusky red; -Moderate amount of foul, purulent drainage noted to wound; -Wound deteriorating. Review of the resident's nurses notes, dated 10/25/19, showed staff documented: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Pressure wound located on coccyx; -Drainage noted to dressing when removed; -Slough present in wound bed (right & left upper buttock wounds); -Dark brown/yellow in color; -Superior wound on upper sacral area has necrotic center, edges appear to be detaching from periwound where granulated tissue is present; -Very foul odor from wound. Review of the resident's care plan, revised 10/25/19, showed staff to encourage/assist with repositioning at least every two hours. Review of the resident's nurses notes, dated 10/28/19, showed staff documented: -Coccyx wound bed 100% yellow green adherent slough; -Moderate amount of green drainage with foul odor; -Complained of moderate amount of pain. Review of the resident's discharge MDS, dated [DATE], showed staff assessed the resident with two Stage II pressure ulcers. Review of the resident's Hospital Wound/Ostomy Nurse Initial Assessment, dated 10/29/19, showed the following: -Arrived to the emergency department with a coccyx (sacrum) wound; -Unstageable wound with black eschar, and yellow slough; -Measures 7 cm length, 7 cm width, and 2.5 cm depth; -Recommend debridement of the wound if the resident is admitted ; -If discharged , recommend an enzymatic (enzyme that eats dead tissue) debridement and fill the rest of the wound depth with moistened kerlix (type of gauze). Review of the resident's Hospital Pressure Ulcer Discharge Assessment, dated 11/1/19, showed the following: -Midline coccyx, Stage IV pressure ulcer; -Moist drainage; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Measures 7 cm in length, 6.4 cm in width, 2.8 cm in depth, 0.5 cm undermining; -Weight 130 lbs. Review of the resident's record showed the resident readmitted to the facility on [DATE]. Review of the resident's nurses notes, dated 11/1/19, showed the following: -Stage III pressure ulcer noted to bilateral buttocks and coccyx (hospital identified the wound as a Stage IV); -Ulcer noted to have soft, black eschar present; -Located to center of black eschar on left buttock; -Open area that measures 1.9 cm x 2.2 cm with undermining present that measures 1.3 cm; -Ulcer to buttocks and coccyx measures 6.9 cm x 7.2 cm.; -Located to bottom of wounds to each buttock, to have dull pink granulation tissue present; -Skin surrounding ulcer noted to be bright pink and blanchable; -Wound noted to have odor present; -Noted left buttock to have a small open area that measures 0.04 cm x 0.2 cm round; -Order for ulcer is wet to dry dressing, change every 6 hours, alternate normal saline and Dakins solution (normal saline and bleach mixture) 0.25% solution, apply Vaseline to healthy skin before dressing; -Pressure relieving mattress in place and Roho cushion in wheelchair. Review of the resident's Wound/Pressure Sore Progress Record, dated 11/4/19, showed the following: -Sacrum Stage III pressure ulcer measures 6.9 cm in length, 7.2 cm in width, and 1.3 cm depth; -Adherent soft black eschar; -Granulation tissue pink &/dull, dusky red; -Moderate amount of serosanguinous drainage noted to wound; -Wound deteriorating. Observation on 11/5/19 at 11:00 A.M., showed the resident's air mattress pump on the end of bed his/her bed set with the resident's weight at 450 lbs. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 11/5/19 at 1:20 P.M., showed the resident lay in his/her bed. Additional observation showed the resident's air mattress pump on the end of bed his/her bed set with the resident's weight at 450 lbs. Observation on 11/5/19 at 1:30 P.M., showed the following: -Licensed Practical Nurse (LPN) C changed the resident's dressing; -Coccyx wound, a Stage IV; -Fibrous white connective tissue at the base of the wound; -Half dollar size opening, black tissue around the wound edges, and deep undermining and tunneling; -Foul odor; -Periwound has Stage III superficial areas on both lower sides of the wound on both sides; -Left area is long, and approximately the size of an egg; -Right area is quarter sized; -Periwound around the left lateral part of the wound is deep red tissue that is non-blanchable, above the wound is purple and non-blanchable; -Air mattress pump on the end of bed the resident's bed set with the resident's weight at 450 lbs. Observation on 11/5/19 at 2:00 P.M., showed the resident lay in his/her bed. Additional observation showed the resident's air mattress pump on the end of bed his/her bed set with the resident's weight at 450 lbs. During an interview on 11/5/19 at 2:07 P.M., LPN C said the following: -The sacral wound is now a Stage IV; -The main opening is half dollar size with deep tunneling and undermining; -There is black tissue and slough; -Not sure what the fibrous white tissue was; -Superficial areas are open and connected to the wound, and extend down the left and right of the wound on each side of the buttock; -A medical equipment company sets up the air mattresses and the settings on the air mattress pump and facility staff do not adjust them; -Staff are expected to ensure the mattress is on and the hoses and plugs fastened; (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The medical equipment company sets the mattress to the resident's weight when the mattress is first delivered to the facility; -Facility staff do not have access to the settings, they are locked. Observation on 11/5/19 at 2:57 P.M., showed the resident lay in his/her bed. Additional observation showed the resident's air mattress pump on end of bed his/her bed set with the resident's weight at 450 lbs. During an interview on 11/27/19 at 10:26 P.M., the facility wound nurse LPN K said the following: -If staff find a pressure ulcer the charge nurse notifies him/her; -He/She is expected to measure the wound, notify the physician, obtain a treatment order, and document a wound assessment; -He/She uses Bates and [NAME] 2001 and an assessment tool for staging wounds dated 2001; -Wound assessments are done weekly on Fridays; -Charge nurses look at the wounds daily with treatments; -Charge nurses are expected to report to him/her if a wound deteriorates, then; -He/She is expected to contact the physician if the wound deteriorates i.e. tissue type, odor, drainage, or increased size; -Pressure wounds should be covered if open; -Wounds with granulation or slough should be covered; -He/She staged the wound wrong, because he/she was using information from 2001, and granulation and slough cannot be in a Stage II wound; -Lantiseptic cream is not recommended for a Stage III wound; -He/She did not notify the physician when the wound opened or when it deteriorated with new slough, purulent drainage, or with odor until 10/18/19, when the physician ordered a surgical consult, because he/she did not know it was a Stage III wound; -He/She did not see the hospital documentation that the wound was a Stage IV; -Air mattress are expected to be used according to the manufacturers instructions and set to the resident's weight; -Charge nurses were responsible for monitoring the air mattresses. During an interview on 11/5/19, at 12:57 P.M., the Director of Nursing (DON) said the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The wound nurse measures and assesses wounds weekly; -The wound nurse is expected to notify the physician if a wound deteriorates; -Resident's equipment and air mattresses should be used according to manufacturer's recommendations. During an interview on 11/25/19, at 5:03 P.M., the resident's physician said the following: -He expected facility staff to notify him of any deterioration of any pressure ulcer; -Facility staff notified him on 9/21/19 by fax, that the resident's buttocks were breaking down, right and left buttock turning colors, and requested a Roho cushion and Super Duper Diaper Doo cream to continue, the physician replied to consult the facility wound nurse; -Facility staff notified him on 9/24/19 by fax and requested an order for Lantiseptic cream to the buttocks wound, the fax did not include a wound description; -From 9/25/19 through 10/8/19 there were no notifications from the facility in regard to the resident; -Facility staff notified him on 10/11/19 by fax to request to change the buttocks treatment from Lantiseptic to Silvadene for Stage II wounds. He replied to agree to the request, the fax did not include a wound description; -On 10/18/19 he ordered to consult the surgeon for wound care; -He received no further notification of wound deterioration or that the wound progressed to a Stage IV pressure wound when the resident returned from the hospital on 11/1/19; -Staff are expected to notify him every time a wound deteriorates; -Lantiseptic is not recommended with a Stage III, or unstageable wound with slough, it should be covered and he would have used a different dressing if he had been informed; -All equipment is expected to be used according to the manufacturer and if there is a setting to be set to the resident's weight it should be set appropriately; -Staff are expected to alert him of a wound deteriorating prior to becoming a Stage IV wound so a different course of action can be attempted; -Earlier intervention and advanced treatments may have helped the wound to heal or prevented deterioration of the wound to a Stage IV. He would have ordered the surgical consult when the wound became a Stage III; -The resident did not have a diagnosis that would make the pressure ulcer unavoidable, the resident was high risk. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	MO00162525

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to consistently implement, evaluate, and modify interventions as necessary to address prevention of falls for two residents (Resident #55 and #96), and failed to properly use a gait belt and safely transfer one resident (Resident #96), in a review of 20 sampled residents. The facility census was 99. 1. Record review of the facility's Falls Management Program Policy, dated as revised 7/20/09, showed the following: -A Fall refers to unintentionally coming to rest on the ground, floor or other lower level but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred; -An Un-witnessed fall occurs when a resident is observed on the floor and neither the resident nor anyone else knows how he/she got there; -Post-Fall Management: Place individual on the HOT LIST (a form of charting which is problem-focused to obtain needed assessment data to evaluate needs and effectiveness of treatments and/or orders) and document on every shift for three days and perform neurological checks as guided; -All falls will be logged by the clinical supervisor or authorized person and reviewed regularly by the interdisciplinary team; -All incident report forms will be sent to the clinical supervisor for review. The clinical supervisor will track all falls for each individual and investigate the initial cause of the fall(s). The care plan team will discuss the falls on a regular basis and confer about potential preventative fall measures and measures to minimize injuries from falls. 2. Review of Resident #96's admission Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff dated 8/6/19 showed the following: -Moderately impaired cognition; -No behaviors; -Independent with transfers; -Walking, not steady but able to stabilize without human assistance; -Surface to surface transfer, not steady but able to stabilize without human assistance; -Used a walker for mobility; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Diagnoses of psychotic disorder and heart failure; -No falls in the last month prior to admission; -Had a fall in the last 2-6 months prior to admission. Review of the resident's undated fall risk assessment showed a score of 12 indicating high risk for falls. Review of the resident's care plan revised 8/9/19 showed the following: -High risk for falls related to multiple disease processes and history of falls; -Keep call light within reach and answer promptly; -Keep glasses clean and free from scratches; -Keep items resident may want within reach; -Keep non-skid socks or shoes on at all times; -Keep pathways clear and free of clutter. Review of the resident's nurse's notes dated 8/9/19 at 2:44 P.M. showed the following: -Therapy reports resident is minimum assist with bed mobility and transfers and ambulating 75 feet with front wheeled walker; -Needs cues for safety awareness set up/supervision with dressing and toileting. Review of the resident's nurses' notes dated 8/13/19 at 3:16 P.M. showed the resident ambulates with a walker and has a steady gait. Review of the resident's nurses' notes dated 8/16/19 at 2:41 P.M. showed the following: -Resident continues to complain of right hip being sore; -Able to walk and sit with minimal difficulty; -Refuses assistance from staff; -Received new order this morning for X-ray of right hip and pelvis. Review of the resident's nurses' notes dated 8/19/19 at 3:32 P.M. showed the resident was unable to ambulate with his/her walker as he/she usually had. Review of the resident's nurse's notes dated 8/19/19 at 8:15 P.M. showed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Resident continues with increased confusion; -Resistive to care; -Striking out at staff; -Unable to ambulate with assist and walker requiring use of wheelchair; -Currently resting in recliner in core area. Review of the resident's nurse's notes dated 8/19/19 at 11:52 P.M. showed the following: -CNA alerted nurse that resident had fallen straight forward out of his/her wheelchair; -This nurse responded to unit and observed resident laying on his/her left side with his/her head towards the nurses' station; -His/her arms and legs were curled up in fetal position and his/her face and forehead were against the ground; -Resident assessed and noted to have large knot to middle of forehead; -He/She also had a skin tear to left forearm measuring 0.5 centimeters (cm); -Skin tear dressed with Vaseline gauze and gauze wrap, edges approximated; -Arms and legs noted to be in proper alignment, but resident not able to follow commands to move them; -Resident unresponsive so unable to perform full neuro checks; -Staff reports that resident has been confused and combative throughout the shift, but had slumped over in his/her wheelchair around 10 P.M. and was not responding to them; -Resident assisted to recliner by staff x3; -Resident sent out per ambulance. Review of the resident's medical record showed no evidence staff evaluated current fall interventions or implemented new interventions after the 8/19/19 fall. Review of the resident's nurses' notes dated 8/20/19 at 7:59 P.M. showed the following: -Resident unable to ambulate requiring use of wheelchair; -Resistive to care; -Continues with increased confusion; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Fax sent to physician with information from visit to ER; -Return fax received with no new orders; -Family member here and fed resident. Review of the resident's nurses' notes dated 8/21/19 at 6:06 A.M. showed the following: -Resident resting in recliner in core area. Has slept fairly well here all night; -Continues on fall follow-up; -Neuro checks remain WNL except resident had difficulty understanding the hand grasp portion early in the shift. That has improved this A.M.; -Abrasion remains to center of forehead; -Resident noted to be unable to ambulate; -One assist, two at times, needed to transfer to wheelchair; -Resident seems to be having difficulty with vision as well, especially with depth perception. Noted to be reaching out for items such as the grab bar or water cup, but is not reaching far enough to actually grab the item; -This nurse asked if the resident if he/she was seeing double and he/she said no. Will continue to monitor. Review of the resident's nurses' notes dated 8/22/19 at 7:51 A.M. showed the following: -Resident was in a recliner in the special care unit and refused to get up for bathroom or to go to bed; -Resident was combative with staff and verbally abusive; -Contacted physician at 9:35 P.M. after resident continued to try and hit aides; -Physician ordered Lorazepam (anti-anxiety medication)2 mgg by mouth now, and1 mgg every 8 hours as needed for aggression; -Can give intramuscular (IM) Lorazepam if unable to take orally. Resident has a wound to left forearm 2L x 1/4 diameter. Review of the resident's nurses' notes dated 8/22/19 at 8:30 A.M. showed the following: -Resident was found on floor in his/her room at bed check; -Resident had earlier been kicking and pinching staff at bed checks; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Aide went into room at 5:10 A.M. and found resident on floor with blood on floor and resident had a head wound; -Resident was laying on right side with right arm under body, blood on face, and was alert; -Resident was assessed head to toe, wounds also noted on right elbow two skin tears, small skin tear on right wrist, cut to upper right lip, bruise on nose, and open laceration above left eyebrow, and bruising to right hip with abrasion; -Resident complains also of left leg pain; -Sent out to ER via ambulance at 5:45 A.M. Review of the resident's nurses' notes dated 8/22/19 at 7:30 A.M. showed the following: -Received report from nurse at ER; -Resident is ready to return to facility; -Resident has had a negative head CT scan (imaging to assess for injury), and has 2-3 sutures in his/her fore head which will dissolve on their own. Review of the resident's significant change MDS dated [DATE] showed the following: -Severe cognitive impairment; -Physical behavioral symptoms occurred 4-6 days of the last seven days; -Verbal behavioral symptoms occurred 4-6 days of the last seven days; -Rejection of care 1-3 days of the last seven days; -Required extensive assist of two or more staff for transfers; -Two or more non-injury falls since prior assessment; -Two or more injury falls (not major) since prior assessment. Review of the resident's fall risk assessment dated [DATE] showed a score of 17 indicating high risk for falls. Review of the resident's care plan revised 9/11/19 showed the following: -Decline in ADL and mobility performance related to low endurance and weakness from recent hospital stay; -Resident requires extensive assist of two with transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation on 9/10/19 at 10:29 A.M. at the nurses' station showed the following: -The resident sat in a recliner; -CNA Q and CNA I placed a gait belt around the resident's waist; -CNA Q and CNA I pivoted the resident from the recliner to the wheelchair; -Both staff pulled up on the back of the resident's pants during the transfer; -The resident did not bear weight; -During the transfer, the resident's feet slid across the floor and his/her knees were bent. Observation on 9/10/19 at 10:40 A.M. in the resident's room showed the following: -The resident sat in his/her wheelchair beside the bed; -CNA Q and CNA I placed a gait belt around the resident's waist; -CNA Q and CNA I pivoted the resident from the wheelchair to the bed; -Both staff pulled up on the back of the resident's pants during the transfer; -The resident did not bear weight; -During the transfer, the resident's feet slid across the floor and his/her knees were bent. During interview on 09/11/19 at 1:27 P.M. CNA Q said the following: -The resident was not bearing weight well at all during the transfers; -The resident's knees were bent and his/her feet slid across the floor; -The resident did not seem to follow simple commands; -He/She and CNA I had to pull up on the back of the resident's pants to transfer him/her. 2. Record review of Resident #55's quarterly MDS dated [DATE], showed the following: -Severe cognitive impairment for daily decision making; -Independent with no help from staff with bed mobility, transfer, walking in room, walking in corridor, and toileting; -Required supervision with setup help only for dressing and personal hygiene; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Was not steady, but able to stabilize without staff assistance with moving from seated to standing position, walking, turning around, moving on and off the toilet, and surface to surface transfer; -Had no functional limitation in range of motion of the upper and lower extremity; -Used a walker for mobility; -Had no falls since last assessment (1/11/19). Review of the resident's nurse's notes, dated 6/25/19 at 12:49 A.M., showed the resident had been wandering the halls, leaving his/her walker in various places at times. Review of the resident's nurse's notes, dated 7/1/19 at 1:31 P.M., showed the nurse was called to the resident's room and it was reported a housekeeper went into the resident's room and heard the resident calling for help. Upon opening the bathroom door, the resident was noted to be sitting on the floor. The housekeeper called for staff to help assist the resident. When staff entered the room they noted the resident scooting out of the bathroom on his/her buttocks. The nurse walked into the room shortly after and noted the resident sitting outside the bathroom door on his/her buttocks. There was bowel movement noted to the floor of the bathroom and appeared the resident had slipped and fallen on the stool. The resident's walker was found beside his/her bed. The resident had walked to the bathroom unassisted. No apparentinjuriess noted. The resident denied hitting his/her head, but neurological assessment initiated. Review of the resident's nurse's notes, dated 7/27/19 at 3:56 P.M., showed the resident was observed in the dining area sitting on the floor beside his/her walker. No injuries noted. Neurological assessment initiated. Review of the resident's nurse's notes, dated 8/14/19 at 2:39 P.M., showed the resident observed by the nurse sitting on the floor in the dining area with his/her walker to his/her side. No injuries noted. Neurological assessment initiated. Review of the resident's care plan, dated as last reviewed 9/3/19, showed the following: -Focus: High risk for falls related to history of falls and multiple disease processes (date initiated: 2/18/2015); -Interventions: Keep glasses clean and free from scratches (date initiated: 2/18/2015). Keep items theresidentt may want within reach (date initiated: 2/18/2015). Keep non skid socks or shoes on at all times (date initiated: 2/18/2015). Keep walker within reach at all times (date initiated: 2/18/2015). Provide adequate lighting (date initiated: 2/18/2015). Encourage the resident to request assistance with making his/her bed (date initiated: 11/3/2015). Up as needed in the facility with four wheeled walker, make sure walker is always within reach (date initiated 1/19/2017). Keep call light within reach and answer promptly (date initiated: 7/21/2017). Encourage and assist theresidentt to the bathroom at least every two hours (date initiated: 10/22/2018); -Staff failed to modify or implement new interventions after the resident fell on [DATE], 7/27/19, and 8/14/19. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/12/19 at 3:20 P.M., Licensed Practical Nurse (LPN) BB said the following: -Nurses can add interventions to the care plan after a fall to ensure another fall doesn't occur; -In some situations staff may need to increase monitoring of the resident to prevent falls and those interventions should be on the care plan. During an interview on 9/12/19 at 4:52 P.M., the Director of Nursing (DON) said the following: -After a fall, staff should look at the interventions and see if those interventions were in place and if not may need to re-educate the resident or staff; -If there are any new interventions that needed to be added to prevent future falls or injury, staff should let the Minimum Data Set (MDS) nurse know, so those interventions can be added to the care plan; -The facility does have a falls committee that looks at all the falls, including the times of the falls and the locations; -It would not be appropriate for staff to transfer a resident who is not bearing weight with a gait belt; -Staff should not pull up on the back of a resident's pants during gait belt transfers.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29982 Based on observation, interview and record review, the facility failed to provide incontinence care with a urinary catheter (a sterile tube inserted into the bladder to drain urine) consistent with acceptable standards of practice, failed to maintain the catheter bag below the level of the bladder, and failed to keep catheter tubing and drainage bag off the floor for two residents (Resident #30 and #81) in a review of 20 sampled residents. The facility census was 99. 1. Review of the undated facility policy titled, Catheter Care, showed: -Purpose: to prevent infection and to keep the resident comfortable and clean; -Catheter bag should be placed on side of bed opposite the direction that resident is turned; -The policy did not address any infection prevention. 2. Review of the Nurse Assistant in a Long-Term Care Facility, Student Reference, 2001 Revision, showed the Steps of Procedure for Giving Peri Care with a Catheter (a sterile tube inserted and left in the bladder to drain urine) included the following instructions: -More frequent care is required for residents who have an indwelling catheter; -Expose the perineal area; separate the labia of the female resident and gently wash around the opening of the urethra with soap and water; -Wash the catheter tubing from the opening of the urethra outward four inches and further if needed; -Using a fresh wash cloth continue washing and rinsing the peri area; -The bladder is considered sterile, the catheter, drainage tubing, and bag are a sterile system; -Drainage tubing/bags must not touch the floor; always hook to unmovable part of the bed frame or chair; -When transferring residents from bed to chair, always move the drainage bag over to the chair before moving the resident; -The drainage bag should always be below the level of the bladder; -If moved above, urine could flow back into the bladder. 3. Record review of Resident #30's Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 6/14/19, showed the following: -Moderately impaired cognition; (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Required extensive assistance of one staff for bed mobility, toileting, and personal hygiene; -Required limited assistance of one staff for transfers; -Had an indwelling urinary catheter; -Was always continent of bowel; -Active Diagnosis included: Urinary tract infection (UTI) in the last 30 days; -No active diagnosis for the resident's indwelling catheter. Record review of the resident's care plan, dated as last reviewed 6/24/19, showed the following: -Focus: Alteration in elimination related to presence of a urinary catheter; -Interventions: Encourage the resident to leave catheter secure in place to prevent catheter from getting pulled. Monitor and document intake and output as per facility protocol. Monitor and document pain or discomfort due to catheter. Monitor/record/report signs and symptoms of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Position catheter bag and tubing below the level of the bladder. Record review of the physician's progress note, dated 7/19/19, showed the following: -Chief complaint: UTI; -Plan: Macrobid (antibiotic)100 milligram (mg) BID (twice a day) for 10 days. Record review of the resident's Nurses Note dated 7/20/2019 at 2:15 A.M., The resident saw physician today and is now on Macrobid 100 mg BID x 10 days. Resident c/o genital pain at 11 p.m. and was given Tylenol two tabs. Record review of the resident's nurse's notes dated 7/22/2019 at 4:56 P.M., showed the resident's urinary catheter was patent and draining yellow urine without difficulty. The resident had no complaints of genital pain noted so far this shift. Received a new order via telephone per the physician to change antibiotic to Augmentin (antibiotic) 875 mg bid x 7 days. Record review of the resident's nurse's notes on 8/16/2019 at 2:30 P.M., showed an order was received for an urinalysis with culture and sensitivity if indicated. A #20 French (size) urinary catheter was inserted with minimal difficulty by the nurse. Cloudy urine with sediment returned. Record review of the resident's final urinalysis culture and sensitivity report, dated as final 8/19/19, showed greater than 100,00 colony-forming units (CFU) per milliliter (ml) of proteus mirabilis (gram negative bacteria that is widely distributed in soil and water). Record review of the residents nurse's notes on 8/19/2019 at 3:07 P.M., showed a new order was received from the physician for Cipro (antibiotic) 250 mg twice a day for 10 days for UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the resident's physician's orders, dated 9/1/19 through 9/30/19, showed the following: -Diagnosis included: UTI and Sepsis (a life-threatening complication of an infection); -Change urinary indwelling catheter monthly and as needed for occlusion and malfunction, use a #20 french; -No diagnosis listed for indwelling catheter. Observation on 9/9/19 at 10:30 A.M., showed the resident in bed with his/her urinary catheter to the right side of him/her hanging from the metal bed frame with the catheter bag and tubing touching the floor. Observation on 9/10/19 at 08:23 A.M., showed the resident in bed on his/her right side with his/her eyes closed, his/her urinary catheter hung from the metal frame on the right side of the bed, the bag and tubing touched the floor. Observation on 9/11/19 at 5:55 A.M., showed the resident in bed on his/her right side, his/her urinary catheter bag and tubing hung from the bed frame and touched the floor. Observation on 9/12/19 at 8:29 A.M.,showed the resident in bed on his/her right side with his/her urinary catheter bag was to the right side of the bed hanging on the metal frame with part of bag and tubing on the floor. 4. Review of Resident #81's face sheet showed diagnoses included urinary tract infections, proteus mirabilis and morganii (bacteria, that once attached to the urinary tract, infects the kidneys) and bulbous urethral stricture (narrowing of the urethra (duct by which urine is conveyed out of the body from the bladder). Review of the resident's Quarterly MDS, dated [DATE] showed the following: -Severely impaired cognition; -Required total dependence of one staff member with toilet use; -The resident had a suprapubic catheter (a hollow flexible tube that is used to drain urine from the bladder, inserted a few inches below the navel). Review of the resident's care plan, revised on 2/4/19, showed: -Required total assistance of staff; -Required total assist of all ADLs; -Alteration in elimination related to suprapubic catheter and bulbous urethral stricture; -Position catheter bag and tubing below the level of the bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/11/19 at 10:43 A.M. showed: -CNA F and CNA K entered the resident's room to give him/her morning care, including a bed bath; -Both CNAs donned gloves; -The resident was on his/her right side in his/her bed; -His/Her suprapubic catheter bag hung on the bed frame; -CNA F removed the resident's suprapubic catheter bag from the bed frame, lifting it in the air, above the mattress and the resident's waist; -The resident's urinary catheter bag contained approximately 250 milliliters (ml) of urine; -Urine ran down the catheter tubing toward the resident's bladder; -CNA F sat the catheter bag on the resident's bed and positioned the resident on his/her back; -CNA F and CNA K rolled the resident back and forth, performing care; -CNA K picked the catheter bag up from the resident's bed, holding it in the air, above the resident's mattress and resident's waist, as CNA F pulled on a draw sheet, positioning the resident on his/her left side; -Urine ran down the catheter tubing toward the resident's bladder; -CNA K then hung the resident's urinary catheter bag on the bed frame. During interview on 9/11/19 at 11:05 A.M., and 11:15 A.M., CNA K and CNA F said catheter tubing should be held and moved so that urine does not back flow into the resident's bladder. During interview on 9/12/19 at 4:51 P.M. the Director of Nursing said: -Catheter bags and tubing should always be kept below the resident's waist level to prevent back flow of urine into the resident's bladder; -Catheter bags should be kept up off of the floor; -Not doing either of these things could cause infections and urinary tract infections. 41412 MO 159742

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on observation, interview, and record review, the facility failed to comprehensively assess pain, provide PRN (as needed) pain medication, and intervene when the resident exhibited crying out during cares for one resident (Resident #71) in a review of 20 sampled residents. The facility census was 99. 1. Review of the facility policy Pain Management revised 11/2009 showed the following: Procedure: 1. Pain will be assessed on a regular basis with the goal of assessment to determine the cause of pain and develop an appropriate individualized treatment plan; 2. Pain screening form will be completed on admission/readmission by nursing, as part of the admitting nursing assessment process or with any new onset of pain-thereafter the form will be completed by the Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, coordinator at least quarterly and with any MDS significant change; 4. The Pain Assessment Flow Sheet will be used to assess pain of resident whose pain is not adequately controlled by occasional as needed (PRN) pain medication or by a regimen of routine pain medications, using the numerical scale 0 (no pain) to 10 (worst possible pain); 5. For the resident who has difficulty communicating, the PAINAD (Pain Assessment in Advanced Dementia) scale will be used; 6. The Pain Assessment Flow Sheet and the Medication Administration Record (MAR) will be filled out every time pain medication is administered. The pain will be assessed each shift to monitor effectiveness of pharmacological and non-pharmacological interventions; 9. The physician will be notified any time assessment reveals inadequate pain control; HIGH RISK FOR PAIN DIAGNOSIS: -ARTHRITIS; -IMMOBILITY/CONTRACTURES (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints); -PRESSURE ULCERS (localized damage to the skin and/or underlying tissue that usually occur over a bony prominence as a result of usually long-term pressure, or pressure in combination with shear or friction). 2. Review of Resident #71's face sheet showed the following: -admitted to the facility on [DATE]; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Diagnoses of stiffness of right hip, left hip, right knee and left knee, pressure ulcer of unspecified heel, unspecified dementia with behavioral disturbance, unspecified osteoarthritis (degeneration of joint cartilage and the underlying bone, most common from middle age onward. It causes pain and stiffness, especially in the hip, knee, and thumb joints), rheumatoid arthritis (an autoimmune disease in which the body's own immune system attacks the body's joints) and age related osteoporosis (a disease in which bone weakening increases the risk of a broken bone). Review of the resident's care plan dated 3/12/2016 showed the following: -Resident is requiring extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene at this time. Encourage him/her to do as much for him/herself as possible; -Potential for alteration in health status related to multiple disease processes; -Monitor for pain/discomfort and address accordingly; -Notify physician of any change in health status; -Alteration in thought process related to dementia, senile/presenile psychosis; -Be alert to triggers creating negative responses, such as hunger, thirst, pain, toileting needs, lack of social intervention, boredom, or care actions that could be negatively affecting the resident. Review of the resident's quarterly MDS dated [DATE] showed the following: -Short and long term memory problems; -Clear speech, makes self understood; -Physical behavioral symptoms occurred 1-3 days of the last seven days; -Verbal behavioral symptoms 1-3 days of the last seven days; -Totally dependent on staff for personal hygiene, bathing and toilet use; -Has not been on scheduled pain medication regimen; -Has not received PRN pain medication; -Has not received non-medication interventions for pain; -Lower extremity impairment on both sides. Review of the resident's Pain Screening Form dated 7/29/19 showed a score of three indicating comprehensive pain assessment not needed. Review of the resident's monthly summary dated 8/3/19 showed the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pain frequency: Occasionally; -Pain intensity numeric=0; -Verbal descriptor: N/A; -Indicators of pain: Vocal complaints of pain; -Contractures: Leg and foot; -Overall monthly condition report: No signs/symptoms of pain or discomfort. Resident continues to holler out several times a day for no reason. Review of the resident's September 2019 physician's orders showed an order for Acetaminophen (pain reliever) 160 milligrams (mg)/ 5 milliliters (ml) give 30 ml by mouth every six hours as needed for pain. Review of the resident's Medication Administration Record (MAR), dated 9/1/19-9/12/19 showed staff did not administer any acetaminophen for pain. Observation on 9/10/19 at 2:36 P.M. in the resident's room showed the following: -The resident lay in bed; -He/She was incontinent of urine and stool; -Certified Nurse Aide (CNA) DD and CNA P rolled the resident from side to side in bed; -The resident cried out, Ow, please stop! Ow, please help me! -CNA DD said the resident's yelling/screaming was a behavior; -CNA P provided pericare; -The resident screamed out loudly during care You're hurting me, yes you are. Observation on 9/11/19 at 9:00 A.M. in the shower room showed the following: -The resident lay in the fetal position on a shower gurney; -CNA P provided rectal pericare; -The resident grunted and yelled out, Ow, Ow while being washed; -The resident's legs were contracted; -The resident yelled out loudly, Stop! Ow Ow! while CNA P dried between the resident's legs; (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-CNA P lifted the resident's hips and placed a clean incontinence brief; -The resident yelled' Ow, Ow! -CNA P said I know; -CNA P applied the resident's clean sweater; -The resident yelled, You're hurting me, please don't; -CNA P repeatedly said, I'm not hurting you; -CNA P lifted up the resident's head and the resident screamed loudly; -CNA P pulled up the resident's pants; -The resident yelled out repeatedly, You're hurting me! -CNA P said, I'm not trying to hurt you; -The resident hit CNA P with his/her right fist; -CNA P rolled the resident back and forth and placed a clean mechanical lift pad under the resident; -During repositioning the resident screamed, Are you going to kill me? Are you going to kill me? During interview on 9/11/19 at 2:52 P.M. CNA P said the following: -He/She thinks the resident's screaming is a behavior and not pain; -The resident's legs are very contracted and do not straighten out easily so the resident often cries out with cares including repositioning, incontinence care, etc.; -Movement with care is probably hurting the resident, but staff have to get the resident's legs straightened out. During interview on 9/11/19 at 3:35 P.M. CNA JJ said the following: -The resident says he/she hurts all the time, if he/she was having pain it would be a more extreme scream; -The resident is contracted; -Stretching the resident's arms and legs to dress him/her could cause pain. During interview on 9/11/19 at 4:03 P.M. CNA HH said the following: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident hollers out with repositioning, the resident says it hurts; -The resident is able to say if he/she is hurting; -The resident is very contracted. During interview on 9/11/19 at 2:01 P.M. Restorative Aide (RA) KK said the following: -He/She performs passive range of motion with the resident; -The resident doesn't tolerate it well most of the time; -Sometimes the resident will hit him/her and if the resident does that then it's probably hurting him/her. During interview on 9/12/19 at 2:43 P.M. Licensed Practical Nurse (LPN) O said the following: -The resident doesn't have pain, his/her yelling out is more behavior; -Pain assessments are completed on admission and if a resident receives scheduled or PRN pain medication; -If the resident exhibited grimacing, groaning, or moaning, he/she would intervene and address the resident's pain with the physician; -Because it's this resident, 98% of what he/she does is a behavior. He/She would take that into account; -He/she would expect CNA staff to report to him/her if the resident complained of pain. During interview on 9/12/19 at 4:52 P.M. the Director of Nursing (DON) said the following: -At times the resident will say ouch and exhibit facial grimacing; -If staff is providing care and the resident complains of pain, he would expect staff to try to do the procedure in a different way; -He would expect staff to administer PRN acetaminophen if the resident exhibits signs/symptoms of pain; -He would expect staff to notify the nurse if the resident complains of pain during care; -He would expect staff to assess pain if an as needed pain medication was administered.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36219 Based on interview and record review, the facility failed to develop a policy and procedure, based on current standards of practice, to address the care of residents receiving dialysis services. The facility failed to monitor the dialysis access sites for one resident (Resident #80), in a review of 20 sampled residents, and for one additional resident (Resident #76) according to standards of practice. The facility identified two residents received dialysis services. The facility census was 99. 1. Review of Nursing Management: The Journal of Excellence in Nursing Leadership, October 2010, Volume 41, Issue 10, Caring for a Patient's Vascular Access for Hemodialysis showed the following: -A patient in end-stage kidney disease relies on dialysis to mechanically remove fluid, electrolytes, and waste products from the blood. For the most effective hemodialysis, the patient needs good vascular access with an arteriovenous (AV) fistula or an AV graft (access used to artificially connect a vein with an artery, so that a higher blood flow is created to allow blood to be pumped out of the body to an artificial kidney machine, and returned to the body by tubes that connect the patient to the machine) that provides adequate blood flow. Follow your facility's policies and procedures and these clinical tips to protect and preserve the vascular access and avoid complications such as infection, stenosis, thrombosis, and hemorrhage: -Assess for patency at least every eight hours. Palpate the vascular access to feel for a thrill or vibration that indicates arterial and venous blood flow and patency. Auscultate the vascular access with a stethoscope to detect a bruit or swishing sound that indicates patency. -Check the patient's circulation by palpating his/her pulses distal to the vascular access; observing capillary refill in his/her fingers; and assessing him/her for numbness, tingling, altered sensation, coldness, and pallor in the affected extremity. -Assess the vascular access for signs and symptoms of infection such as redness, warmth, tenderness, purulent drainage, open sores, or swelling. Patients with end-stage kidney disease are at increased risk of infection. -After dialysis, assess the vascular access for any bleeding or hemorrhage. 2. Review of Resident #76's face sheet showed the resident was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease (longstanding disease of the kidneys leading to renal failure) and Type II diabetes (a chronic condition that affects the way the body processes blood sugar). Review of the resident's Physician's Orders Sheets (POS), dated 9/1/19 through 9/30/19, showed dialysis on Monday, Wednesday, and Friday at 11 A.M., has to be there at 10:45 A.M. and needs lunch sent with him/her. Review of the resident's care plan, dated as initiated 8/17/18 and last reviewed on 9/3/19, showed the following: -Focus: The resident is currently on dialysis related to renal failure; (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions: Do not draw blood or take blood pressure from the left arm as it is the arm with the graft. The resident has dialysis on Monday, Wednesday, and Friday. Monitor and dress access site per physician's orders. Monitor for signs and symptoms of infection to access site: redness, swelling, warmth or drainage. Monitor for signs and symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds. Monitor for signs and symptoms of the following: bleeding, hemorrhage (the release of blood from a broken vessel, either inside or outside of the body), bacteremia (presence of bacteria in the bloodstream), and septic shock (a widespread infection causing organ failure and dangerously low blood pressure). Monitor labs and report to the physician as needed. Record review of the resident's nurse's notes, dated 7/1/19 through 9/11/19, showed the following: -No documentation of assessment or monitoring of the resident's dialysis catheter (used for exchanging blood to and from a hemodialysismachineg and a patient); -No documentation of assessing or monitoring the resident before or after dialysis treatments. During an interview on 9/10/19 at 10:57 A.M., Registered Nurse (RN) CC said the following: -As far as he/she knew the facility did not do assessments on dialysis residents prior to or after returning to the facility from dialysis; -He/ She did observe the site, but didn't document anything unless there was an issue with the site. 3. Review of Resident #80's face sheet showed the following: -admitted to the facility on [DATE]; -Diagnosis of end stage renal disease (the last stage (stage five) of chronic kidney disease. This means kidneys are only functioning at 10 to 15 percent of their normal capacity). Review of the resident's admission MDS dated [DATE] showed the following: -Cognitively intact; -No rejection of care; -Received dialysis. Review of the resident's care plan revised 7/21/19 showed the following: -Resident is on dialysis related to end stage renal disease and renal osteodystrophy (a bone disease that occurs when the kidneys fail to maintain proper levels of calcium and phosphorus in the blood); -Do not draw blood or take blood pressure in arm with graft. PERMACATH (a special IV line into the blood vessel in the neck or upper chest just under the collarbone) IS IN RIGHT CLAVICLE; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor for sign/symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds; -Monitor for signs/symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock; -Resident goes to dialysis on Tuesdays, Thursdays, and Saturdays. Record review of the resident's nurse's notes, dated 7/8/19 through 9/11/19, showed the following: -No documentation of assessment or monitoring of the resident's dialysis catheter (used for exchanging blood to and from a hemodialysismachineg and a patient); -No documentation of assessing or monitoring the resident before or after dialysis treatments. During interview on 9/10/19 at 10:04 A.M. the resident said the following: -He/She has a dialysis catheter in his/her chest; -Facility staff do not look at or do anything with his/her dialysis catheter. During interview on 9/11/19 at 2:39 P.M. Licensed Practical Nurse (LPN) O said the following: -He/She did not know what kind of dialysis catheter the resident had; -He/She does not do anything with the resident's dialysis catheter; -The resident has no treatments ordered for his/her dialysis access; -He/She does not assess the resident's dialysis catheter; -There is nothing special about the resident's assessments; -The staff does not monitor the resident's blood pressure or for fluid overload; -He/She has not had any specific training on how to care for dialysis residents; -He/She thinks the resident goes to dialysis two times a week. During interview on 9/11/19 at 4:47 P.M. and 9/12/19 at 4:50 P.M. the Director of Nursing (DON) said the following: -The facility did not have a policy for dialysis; -Facility staff transport the residents to and from dialysis treatments; -Facility staff should assess the resident and the dialysis access site after dialysis.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29982 Based on interview, and record review, the facility failed to ensure resident's medication regimens were free from unnecessary medications when the facility failed to show adequate indications for use of an antipsychotic medication (a class of medication primarily used to manage psychosis (including delusions, hallucinations, paranoia or disordered thought), principally in schizophrenia and bipolar disorder) use, failed to have a system to monitor the residents to ensure gradual dose reductions (GDR) were made in an effort to reduce or discontinue the medications and failed to ensure that orders for as needed (PRN) psychotropic medications were limited to 14 days as required except when an attending physician believed it was appropriate the PRN order be extended beyond 14 days, then the physician should document their rationale in the resident's medical record and indicate the duration for the as needed order for three residents (Resident #4, #96, and #148) in a review of 20 sampled residents. The facility census was 99. 1. Review of the facility policy titled Antipsychotic Medication Utilization, dated 12/5/13 showed: -Antipsychotic medications will be utilized appropriately with physicians and the interdisciplinary team through evaluations and monitoring: -The facility will make every effort to comply with state and federal regulations related to the use of antipsychotic medications in long term care to include regular review for continued need, appropriate dosage, side effects risks and/or benefits; -Efforts to reduce dosage or discontinue antipsychotic medications will be ongoing, as appropriate, for the clinical situation; Responsible Party - Actions Required: Primary care physician: -Orders for antipsychotic medication only for the treatment of specific medical and/or psychiatric conditions or when the medication meets the needs of the resident to alleviate significant distress for the resident not met by the use of non-pharmacologic approaches; -Documents rationale and diagnosis for use and identifies target symptoms. -Evaluates/monitors, effects and side effects of antipsychotic medications within one month of initiating, increasing, or decreasing dose through the interdisciplinary teams' assessments and during routine visits thereafter; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Attempt a gradual dose reduction (GDR) decrease or discontinuation of antipsychotic medications after no more than 3 months unless clinically contraindicated. Gradual dose reduction must be attempted for 2 separate quarters (with at least one month between attempts). Gradual dose reduction must be attempted annually thereafter or as the resident's clinical condition warrants, unless the physician has documented at least annually that this would not be indicated or in the patient's best interest; -Orders for PRN antipsychotic medications will be time limited; -Obtains psychiatric consultation as resident's clinical condition requires. -Responsible Party - Actions Required: Nursing : -Monitors antipsychotic drug use daily noting any adverse effects such as increased somnolence or functional decline; -Will monitor for the presence of target behaviors on a daily basis charting by exception (i.e., charting only when the behaviors are present); -Reviews the use of the medication with the physician and the interdisciplinary team on a quarterly basis to determine the continued presence of target behaviors and/or the presence of any adverse effects of the medication use; -May develop behavioral care plans; -Responsible Party - Actions Required: Pharmacist and/or Consulting Pharmacist: -Monitors antipsychotic drug use in the facility to ensure that medications are not used in excessive doses or for excessive duration; -Participates in the interdisciplinary quarterly review of resident's on antipsychotic medications; -Notifies the physician and the DON if whenever an antipsychotic medication is due or past due for review; -Responsible Party - Actions Required: Medical Director: -Monitors the overall use of these medications in the facility through the QAPI process; -Identifies any resident care or potential regulatory issues with the use of antipsychotic medications in the facility and discusses with the medical staff as appropriate; -Participates in the interdisciplinary quarterly review of resident's on antipsychotic medications, as needed, and facilitates communications with attending physicians. 2. Review of Resident #4's care plan, revised 11/28/18, showed: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident had a diagnoses of depression and anxiety for which he/she had medication; -Psychotropic medication related to diagnosis of depression and anxiety; -Resident will be on the lowest possible therapeutic dose to minimize decreased interactions with staff and friends, tearfulness and possible increased respirations and increased anxiousness; -Pharmacy consultant to monitor antipsychotic drugs to ensure that the medications are not used in excessive doses or for excessive duration. Review of the resident's Annual Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 5/17/19 showed: -Diagnoses included anxiety and depression; -The resident received anti-anxiety medication seven of the last seven days; -The resident received anti-depressant medication seven of the last seven days; -No documentation of a gradual dose reduction (GDR) of these medications or that a dose reduction was contraindicated by the physician. Review of the resident's August 2019 physician order sheets (POS) showed: -Xanax (psychotropic medication for anxiety) 0.5 milligrams (mg) twice daily (order date 8/29/18); -Xanax 0.5 mg four hours as needed (PRN) for increased anxiety (order date of 8/3/19); (open ended order with no limitation on number of days); -Lorazepam (psychotropic medication for anxiety) 0.5 mg every four PRN for mild to moderate anxiety/agitation (order date of 8/15/19); (open ended order with no limitation on number of days); -Lorazepam 1 mg every four PRN for severe anxiety/agitation (order date of 8/15/19); (open ended order with no limitation on number of days). Review of the resident's August 2019 medication administration record (MAR) for 8/1/19 through 8/16/19, showed staff documented the following: -Administering the resident's Xanax 0.5 mg twice daily as ordered at 8:00 A.M. and 8:00 P.M.; -No administration of the resident's Xanax 0.5 mg every four hours PRN for increased anxiety; -No administration of the resident's Lorazepam 0.5 mg every four PRN for mild to moderate anxiety/agitation on; -No administration of the resident's Lorazepam 1 mg every four PRN for severe anxiety/agitation. Review of the Consultant Pharmacist Communication to Physician dated 8/16/19 showed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-New regulations in effect November 28, 2017 require all PRN psychotropic medications (including Lorazepam and Xanax, even in Hospice residents) to be limited to 14 days; -Therefore, in order for the facility to remain compliant, the PRN order for Lorazepam and Xanax needs to be discontinued; -Please review and consider DISCONTINUING the PRN orders for Lorazepam and Xanax; -NOTE: The order MAY be continued beyond 14 days IF THE PRESCRIBER OR ATTENDING PHYSICIAN DOCUMENTS THE RATIONALE FOR CONTINUING THE ORDER AND PROVIDES A STOP DATE FOR THE ORDER. HOWEVER, THIS MUST BE DONE NO LONGER THAN EVERY 60 DAYS IN ORDER TO ENSURE FACILITY COMPLIANCE; -Physician response to recommendation/finding: blank. Review of the resident's significant change MDS dated [DATE] showed the following: -Diagnoses included anxiety and depression; -The resident received anti-anxiety medication seven of the last seven days; -The resident received anti-depressant medication seven of the last seven days; -The resident received hospice services; -No documentation of a GDR of these medications or that a dose reduction was contraindicated by the physician. Review of the resident's August 2019 medication administration record (MAR) dated 8/17/19 through 8/31/19 showed staff documented: -Administering the resident's Xanax 0.5 mg twice daily as ordered at 8:00 A.M. and 8:00 P.M. 8/17/19 through 8/31/19; -No administration of the resident's Xanax 0.5 mg four hours PRN for increased anxiety; -Administering the resident's Lorazepam 0.5 mg every four PRN for mild to moderate anxiety/agitation on 8/18/19; -No administration of the resident's Lorazepam 1 mg every four PRN for severe anxiety/agitation. Review of the resident's September 2019 POS showed: -Xanax 0.5 mg twice daily; -Xanax 0.5 mg four hours PRN for increased anxiety (order date of 8/3/19); (open ended order with no limitation on number of days); (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Lorazepam 0.5 mg every four PRN for mild to moderate anxiety/agitation (order date of 8/15/19); (open ended order with no limitation on number of days). Review of the resident's September 2019 MAR showed staff documented: -Administering the resident's Xanax 0.5 mg twice daily as ordered at 8:00 A.M. and 8:00 P.M. 9/1/19 through 9/12/19; -No administration of the resident's Xanax 0.5 mg four hours PRN for increased anxiety; -No administration of the resident's Lorazepam 0.5 mg every four PRN for mild to moderate anxiety/agitation. Record review of the resident's medical record showed: -The facility had no attempted a GDR for the resident's Xanax 0.5 mg twice daily since its order date of 8/29/18; -The resident had PRN orders for Lorazapam and Xanax that were open ended with no limitation on the number of days to be used; -The facility had not ensured the pharmacy consultant recommendation was sent to the physician and a response received. 3. Review of Resident #96's care plan revised 8/9/19 showed the following: -Psychotropic medication related to diagnosis of psychosis; -Resident will be on the lowest possible therapeutic dose to minimize (target behaviors); -Pharmacy consultant to monitor antipsychotic drugs to ensure that the medications are not used in excessive doses or for excessive duration. Review of the resident's physician's orders dated 8/12/19 showed an order for Ambien (hypnotic medication) 5 mg by mouth at bedtime as needed (open ended order with no limitation on number of days). Review of the Consultant Pharmacist Communication to Physician dated 8/16/19 showed the following: -New regulations in effect November 28, 2017 require all PRN psychotropic medications (including Ambien) to be limited to 14 days; -Therefore, in order for the facility to remain compliant, the PRN order for Ambien needs to be discontinued; -Please review and consider DISCONTINUING the PRN order for Ambien; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-NOTE: The order MAY be continued beyond 14 days IF THE PRESCRIBER OR ATTENDING PHYSICIAN DOCUMENTS THE RATIONALE FOR CONTINUING THE ORDER AND PROVIDES A STOP DATE FOR THE ORDER. HOWEVER, THIS MUST BE DONE NO LONGER THAN EVERY 60 DAYS IN ORDER TO ENSURE FACILITY COMPLIANCE; -Physician response to recommendation/finding: blank. Review of the resident's August 2019 Medication Administration Record (MAR) showed staff did not administer PRN Ambien. Review of the resident's September 2019 MAR showed the following: -On 9/1/19 at 10:00 P.M. staff documented administering Ambien 5 mg for sleep; -On 9/4/19 at 1:00 A.M. staff documented administering Ambien 5 mg for insomnia. Review of the resident's significant change MDS dated [DATE] showed the following: -Severe cognitive impairment; -Received hypnotic medication two of the last seven days; -Diagnoses of psychotic disorder and heart failure. 4. Review of Resident #148's admission physician's orders, dated 8/30/19, showed the following: -Diagnosis included: Alzheimer's (progressive disease that destroys memory and other important mental functions), daytime hypersomnolence (recurrent episodes of excessive daytime sleepiness or prolonged nighttime sleep), and depression (mood disorder that may be described as feelings of sadness, loss, or anger); -Risperdal (antipsychotic) 0.25 milligram (mg) at bedtime. Review of the resident's initial care plan, dated 8/30/19, showed the admitting diagnosis: Dementia (a group of thinking and social symptoms that interferes with daily functioning); Review of the resident's record showed no diagnoses supporting the use of Risperdal. During interview on 9/11/19 at 1:50 P.M. and 9/12/19 at 4:52 P.M. the DON said the following: -Resident #148 had a diagnosis of combative Alzheimer's dementia and that was the diagnosis that should have been used for the Risperdal; -He would expect staff to obtain GDRs or orders per the regulation guidelines; -He would expect PRN psychotropic medications to have a 14 days stop date; -The pharmacist recommendations were just now received; (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It took the pharmacist a while to get the recommendation sheets to him; -The pharmacist recommendations were now being sent to the physician for response. 36219 41412

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 29982 Based on observation, interview, and record review, the facility failed to ensure staff prepared and served food items according to the dietary spreadsheet menu for residents on physician-ordered gluten free and renal diets. The facility census was 99. 1. Review of Resident #148's physician order sheet for September 2019 showed an order for a gluten free diet. Review of the menu for gluten free diets for the evening meal on 9/9/19 showed the following: -Open faced roast beef sandwich (gluten free); -Homemade mashed potatoes; -Corn; -Cookies (gluten free) Observation on 9/9/19 at 5:52 P.M. showed staff only served the resident mashed potatoes and corn. During an interview on 9/9/19 at 6:15 P.M., the resident said he/she only received corn and mashed potatoes for his/her meal. It would have been nice to have something else and he/she would have eaten it if it was served. He/She was on a gluten free diet but could have, and would have eaten, the roast beef. He/She would have liked to have some dessert and would have eaten the banana pudding or any other dessert offered. 2. Review of Resident #76's physician order sheet for September 2019 showed an order for a renal diet. Review of the menu for renal diets for the evening meal on 9/9/19 showed the following: -Open faced roast beef sandwich; -Buttered noodles; -Corn; -Sugar cookies. Observation on 9/9/19 at 5:53 P.M. showed staff served the resident a meal of meat, bread, and corn. Staff did not serve the resident any buttered noodles or dessert. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 9/10/19 at 3:10 P.M., the dietary manager said Resident #148 should have received everything on the menu last night (9/9/19) except for the bread. He/She tried to keep gluten free bread, pasta, and pizza crust on hand. Staff should have followed the menus for renal and gluten free diets and both residents should have received something for dessert. 33955

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 29982 Based on observation, interview, and record review, the facility failed to ensure staff prepared food items according to the recipe to conserve nutritive value, flavor and appearance. The facility census was 99. 1. Review of the facility's Fresh Ideas Culinary Hospitality Program, undated, showed the following: -To properly prepare a recipe, certain steps must be followed; -Read the recipe from start to finish and make any notes you may have for your supervisor; -Taste the food you are cooking during different stages throughout the process. Even though a recipe lists salt and pepper in quantities, it is important that judgement be your guide. 2. During group interview on 9/11/19 at 10:05 A.M., showed the following: -Resident #51 said most of the food served was barely warm. -Resident #56 said the food looks bad; -Resident #93 said the food spreads all over the plate; -Resident #51 and Resident #66 said what was on the menu is not what was served. During an interview on 9/9/19 at 10:53 A.M., Resident #26 said the food was not good. At times, the food was undercooked and at other times, it was overcooked. He/She said the food was just not very appetizing at times. During an interview on 9/9/19 at 10:30 A.M., Resident #30 said the food was not the greatest. Sometimes the warm food was cold and the food was undercooked. 3. Review of the spreadsheet menu for the lunch meal on 9/9/19 showed cheesy ham and hash brown casserole, buttered peas and carrots, dinner roll with margarine, and cheesecake with topping. Review of the recipe for the cheesy ham and hash brown casserole from the Summer 2019 menu showed the following for 120 servings: -Nine pounds 10 ounces of sour cream; -One and three quarters of 50-ounce can of cream of celery soup; -Seven tablespoons and 1 teaspoon of chives; -Two tablespoons and 1 teaspoon of pepper; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-24 pounds of ground ham; -33 pounds and 10 ounces of shredded hash browns; -One pound 13 ounces of shredded cheddar cheese. -Thaw the ham in the refrigerator up to three days prior to cooking. Observation on 9/9/19 at 12:45 P.M. showed several residents in the dining room outside the special care unit commented they could not find or taste any ham in their hash brown casserole. Observation on 9/9/19 at 12:55 P.M. of the sample tray of hash brown casserole showed there was no ham visible in the dish. The casserole had no flavor, was not well seasoned, and did not taste like ham. The dish appeared and smelled as though it was made with chicken. Observation on 9/9/19 at 1:15 P.M. of Resident #46 showed: -The resident sitting in his/her room with his/her regular diet lunch tray sitting in front of him/her; -The resident's lunch tray contained hashbrown casserole that had a layer of burnt looking cheese on top. During interview on 9/9/19 at 1:18 P.M. the resident said: -The casserole looked terrible; -He/She had peeled back the burnt cheese crust and tried to take a bite but he/she just could not stomach it. During interview on 9/09/19 at 3:03 P.M., Resident #62 said the food was lousy today for lunch. He/She had the casserole for lunch and it did not taste good. During interview on 9/9/19 at 3:29 P.M., Resident #66 said the following: -The food does not come out of the kitchen as it is supposed to; -The food does not taste good; -He/She had the casserole for lunch but it did not taste good. Observation on 9/9/19 at 1:00 P.M. of Resident #75 in the helping hands dining room showed: -The resident sat at the dining room table, a mechanical soft diet plate of food sat in front of the resident; -The hashbrown casserole had a layer of burnt looking cheese on top; (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Certified Nurse Assistant (CNA) K gave the resident a bite of the casserole; -The resident wrinkled up his/her nose and spit the bite out into a napkin. Observation on 9/9/19 at 6:20 P.M. of Resident #75 in the helping hands dining room showed: -The resident sat at the dining room table, a mechanical soft diet plate of food sat in front of the resident; -The plate consisted of ground roast beef, creamed corn, mashed potatoes and gravy; -All of the foods and their juices ran together on the plate. Observation on 9/9/19 at 6:22 P.M. of Resident #52 in the helping hands dining room showed: -Dietary staff U prepared and plated from the steam table, a mechanical soft diet plate of food; -The plate consisted of ground roast beef, creamed corn, mashed potatoes and gravy; -All of the foods and their juices ran together on the plate as CNA Q delivered the plate to the resident. During an interview on 9/9/19 at 1:15 P.M., the dietary manager said he/she wasn't sure what the cook used to make the casserole. The ham that was supposed to be used was not pulled out of the freezer over the weekend so it could not be used due to being frozen. The dietary manager told Dietary Staff V to use the leftover roasted pork loin that was in the refrigerator in place of the ground ham. Upon inspection into the refrigerator, the dietary manager said the casserole was made with leftover pork roast as well as left over chicken breast. During an interview on 9/9/19 at 2:15 P.M., Dietary Staff V said he/she used the left over pork loin and left over chicken breast, which was cooked last week and over the weekend, in place of the ground pork called for in the recipe for cheesy ham and hash brown casserole. Dietary Staff V said he/she used about 80% pork loin and 20% chicken breast and used the same amount of pork and chicken as ham that was called for in the recipe. Dietary Staff V said he/she tried to use up the leftovers and thought it would add to the flavor of the casserole. During an interview on 9/10/19 at 3:10 P.M., the dietary manager said he/she expected staff to follow recipes and taste food prior to service and adjust seasonings as needed. The dietary manager said the ham and hash brown casserole served for lunch on 9/9/19 was dry and needed seasoning. 33955 41412

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Based on observation, interview and record review, the facility failed to maintain equipment clean and free of debris, and failed to store and handle foods in a sanitary and safe manner. The facility census was 99. 1. Review of the facility's Fresh Ideas Culinary Hospitality Program, undated, showed the following: -The first step in preventing food borne disease is good personal hygiene; -Keep hair neat and clean. Always wear a hair net or hat; -Keep shelves and interiors of the coolers clean. 2. Observation on [DATE] at 10:10 A.M. during the initial kitchen inspection showed the following: -The reach-in refrigerator, labeled number six, had a large area of reddish, pink, substance dried on the floor and on the inside of the door; -The reach-in refrigerator, labeled number seven, had a container of garlic with an expiration date of [DATE] and a container labeled chicken and rice with a discard date of [DATE]; -The reach-in refrigerator, labeled number eight, had an open container of cottage cheese with a best by date of [DATE], a container labeled pimento cheese loaf with an open date of [DATE], a container labeled egg salad with an open date of [DATE], and a container labeled macaroni salad with an open date of [DATE]. The refrigerator also had a large container of Caesar dressing with an open date of [DATE], a large container of ranch dressing with an open date of [DATE], and a large container of honey mustard dressing with an open date of [DATE]. During an interview on [DATE] at 1:15 P.M., the dietary manager said staff should discard leftover food within five to seven days, and should discard condiments after one month of being opened. Staff had a daily cleaning schedule to follow which included cleaning the refrigerators and checking food for expiration dates and throwing out leftovers that had not been used in five to seven days. The dietary manager reviewed the expired items and dated items and agreed they were past due to be thrown away. 3. Observation on [DATE] at 10:35 A.M. in the kitchen showed Dietary Staff W had shoulder length hair that was not secured and stuck out from under his/her hair net, as well as a mustache that was not covered by a beard restraint, as he/she washed and put away dishes in the kitchen. Dietary Staff V and the dietary manager wore beard restraints that did not fully cover their facial hair as they prepared and handled food in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on [DATE] at 12:30 P.M. in the kitchen showed Dietary Staff V, Dietary Staff W, and the dietary manager all remained with unrestrained facial hair as they washed dishes and prepared and handled food in the kitchen. Dietary Staff W's head hair remained unsecured under his/her hair net. Observation on [DATE] at 12:40 P.M. showed Dietary Staff Y had a mustache unrestrained by his/her beard net as he/she served residents from a steam table on the Special Care Unit. During an interview on [DATE] at 3:10 P.M., the dietary manager said staff should have all hair secured, including facial hair, while working in the kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33955 Based on observation, interview and record review, the facility failed to ensure that nursing staff washed their hands after each direct resident contact and when indicated by professional practices during personal care, failed to ensure staff did not touch medications during medication administration and failed to ensure staff followed facility policy and procedure during tracheostomy care for three residents (Resident #71, #59, and #81) in a review of 20 sampled residents and one additional resident (Resident #67). The facility census was 99. 1. Review of the facility policy titled, Handwashing and Hand Antisepsis Guidelines, dated 12/2002, showed: -When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non- antimicrobial soap and water or an antimicrobial soap and water. -If hands are not visibly soiled, use an alcohol-based hand rub or an antimicrobial soap and water for routinely decontaminating hands in all other clinical situations described below: -Before having direct contact with patients; -Before donning sterile gloves when inserting a central intravascular catheter -Before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure; -After contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident); -After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled if moving from a contaminated-body site to a clean-body site during resident care; -After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident after removing gloves; -The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores. 2. Review of a facility policy titled. To Prevent and Track the Spread of Infection, dated 2/2009, showed: -Universal Precautions will be maintained at all times; -Infection control measures will be followed as outlined in the INFECTION CONTROL GUIDELINES FOR LONG TERM CARE FACILITIES from Missouri Department of Health; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-We follow the Infection Control Guidelines as updated and posted on The following website: http://www.dhss.mo.gov INursingHomes/Infection_ Control_Guidelines .pdf 3. Review of the facility policy titled, Policy and Procedure - Tracheostomy Care, revised 3/2014, showed: -All care will be provided under a specific doctor order that shall include frequency of care, size and type of trach, using the following procedure to be performed by a Licensed Practical Nurse or Registered Nurse only; -Check doctors order for frequency of care; -Gather all equipment and take to resident room; -Explain procedure to resident, provide privacy and position for comfort; -Wash hands; -Set up supplies on over bed table; -Apply gloves; -Remove inner cannula and place in hydrogen peroxide solution, cleanse the cannula using brush or equipment kit provides; -Rinse cannula in normal saline solution and replace inner cannula; -Remove gloves and wash hands; -Apply gloves, remove dressing at trach site and dispose of properly; -Cleanse around stoma site with hydrogen peroxide and normal saline using q-tip applicators; -Replace with new dressing, replace trach ties as needed, remove gloves and wash hands, dispose of all equipment per policy, clean over bed table; -Make resident comfortable; -Wash hands and document. 4. Review of the facility policy Medication Administration Procedure revised 10/2010 directed staff to not touch medications while administering. 5. Review of Resident #59's Quarterly Minimum Data Set: (MDS), a federally mandated assessment instrument, completed by facility staff, dated 7/18/19 showed the resident received tracheostomy care. Review of the resident's care plan, initiated on 7/24/19, showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Impaired breathing mechanics; -Provide tracheostomy care per physician orders; -Use universal precautions. Review of the resident's September 2019 Physician Order Sheets (POS) showed an order for tracheostomy care per facility policy every shift and as needed. Observation on 9/10/19 10:02 A.M. showed: -Registered Nurse (RN) N gathered supplies needed, entered the resident's room to perform tracheostomy care, setting the supplies on the resident's bedside table. RN N sanitized his/her hands with sanitizer, did not wash his/her hands with soap and water before care, and did not clean the bedside table or apply a barrier to the table before placing the kit on the table; -RN N opened the tracheostomy care kit, removed and donned the included pair of gloves; -With his/her gloved hands, he/she picked up an open bottle of hydrogen peroxide on the resident's dresser, opened the bottle and poured an amount into a section of the tracheostomy care kit tray; -RN N removed the wet, yellow stained gauze dressing from around the resident's tracheostomy site and disposed of it in the trash; -RN N removed the inner cannula of the resident's tracheostomy and placed it in the hydrogen peroxide solution and cleansed the outer and inner part of the cannula with brush included with the kit; -RN N placed the soiled brush on the gauze in the tracheostomy care kit tray (contaminating the gauze), picked up the inner cannula, shook off excess hydrogen peroxide from the cannula and inserted it back into the resident's stoma. RN N did not rinse the cannula in normal saline solution before replacing the cannula; -Without donning clean gloves or washing his/her hands with soap and water, RN N picked up part of the contaminated gauze pads, leaving some in the trach care kit tray, and dipped them in the section of the kit that held the hydrogen peroxide he/she had used to cleanse the inner cannula; -RN N used the contaminated, hydrogen peroxide dampened gauze pads and cleaned around the resident's trach site; -With his/her contaminated gloves, RN N then picked up the remaining gauze pads from the trach kit and secured them around the resident's trach site; -RN N removed his/her gloves, picked up the trach care supplies and disposed of them in the trash; -RN N did not clean the resident's bedside table after use; -RN N did not wash his/her hands with soap and water after the resident's care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In addition, RN N did not remove gloves, wash hands or remove the resident's tracheostomy dressing as the policy instructed. During interview on 9/10/19 at 10:35 A.M., RN N said: -He/She used sanitizer instead of soap and water to wash his/her hands because there just was not enough room in the resident's bathroom to get to the sink; -He/She should not have set the cleansing brush on the gauze pads in the trach care kit; the brush had slipped out of his/her hands and landed on the gauze pads; this contaminated the gauze pads and could cause an infection or respiratory issues; -He/She did not know he/she was to rinse the inner cannula with normal saline before re-inserting the cannula; -He/She should not have dipped the gauze pads in the hydrogen peroxide he/she had used to clean the inner cannula; he/she should have used clean hydrogen peroxide; -The resident did not like the trach care procedure and always wanted to try and talk during, so he/she was in a hurry and had just forgotten or missed some steps. 6. Review of Resident #81's Quarterly MDS, dated [DATE] showed the following: -Severely impaired cognition; -Required total dependence of one staff member with toilet use, personal hygiene and bathing; -Always incontinent of bowel; -Diagnoses included cerebral infarction (stroke), urinary tract infections, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of one side of the body). Review of the resident's care plan, revised on 8/6/18, showed: -Required total assistance of staff; -Required total assist of all ADLs; -Incontinence care with every undergarment change and as needed. Observation on 9/11/19 at 10:43 A.M. showed: -CNA K entered the resident's room to prepare to give him/her morning care, including a bed bath; -CNA K donned gloves; -CNA K washed the resident's buttocks area with soap and water, separating the resident's genitalia from the groin skin folds, cleaning feces from the area; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-After CNA K completed peri-care and positioning the resident, without changing his/her soiled gloves, CNA K gathered a wet washcloth and soapy water and washed the resident's face, using the soiled gloves he/she had used when washing the resident's buttocks, genitalia and groin skin folds; -With the same soiled gloves, CNA K applied [NAME] Stick to the resident's lips. During interview on 9/11/19 at 11:10 A.M., CNA K said he/she knew he/she should change gloves when going from dirty to clean; he/she initially thought he/she had removed all of the feces from the resident's skin, but did clean some between his/her genitalia and groin folds; he/she should have changed his/her gloves before providing any further care; he/she just forgot to change them. 7. Review of Resident #71's care plan revised 11/16/18 showed the following: -Resident is requiring extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene at this time; -Keep resident as clean and dry as possible. Check and change resident's incontinence brief at least every two hours. Review of the resident's quarterly MDS dated [DATE] showed the following: -Short and long term memory problems; -Diagnoses of dementia and depression; -Always incontinent of bladder and bowel; -Totally dependent on one staff for personal hygiene and toilet use. Observation on 9/11/19 at 9:00 A.M. in the shower room showed the following: -The resident lay on the shower gurney in the shower stall in fetal position; -With gloved hands, CNA P washed the resident's back; -CNA P provided rectal pericare; -Feces was visible on the wash cloths; -Without changing gloves or washing his/her hands, CNA P placed shampoo in the resident's hair and washed the resident's hair; -With the same soiled gloves, CNA P picked up the shower head, rinsed the resident hair, picked up a clean towel and dried the resident's hair; -With the same soiled gloves, CNA P dried the resident's back; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-With the same soiled gloves, CNA P placed a clean incontinence brief under the resident's hips, fastened the brief, applied a clean sweater, socks and pants; -CNA P removed his/her gloves and without washing his/her hands, placed a clean cloth mechanical lift pad under the resident. During interview on 9/11/19 at 2:52 P.M. CNA P said he/she usually washes hands and changes gloves after pericare and prior to touching clean items but he/she did not today. 8. Observation on 9/10/19 at 8:45 AM showed the following: -RN N prepared morning medications for Resident #67; -RN N popped two tablets of Tylenol out of a bubble pack. One of the tablets made it into a medication cup, the other tablet landed on the floor in the hallway outside the resident's room; -RN N picked the tablet of Tylenol off the floor and placed it into the medication cup with the other tablet of Tylenol; -The surveyor directed RN N to throw the Tylenol away; -RN N popped two more tablets of Tylenol out of the bubble pack and placed them directly on top of the medication cart, and with bare hands, picked them up and placed them into a medication cup; -RN N popped digoxin 125 micrograms out of a bubble pack and into the medication cup along with the rest of the resident's morning medications; -With bare hands, RN N picked out the tablet of digoxin from the medication cup containing the resident's morning medications, and placed it in another medication cup; -RN N administered the resident his/her medications, including the digoxin. During an interview on 9/10/19 at 3:33 P.M. RN N said he/she would ask a resident if they minded taking a medication that had been dropped on the floor and if they didn't, he/she would administer the medication that had been on the floor. RN N said medications should be placed in a medication cup and not placed directly on the medication cart. RN N said he/she picked out the resident ' s digoxin with his/her bare hands because it is in a package with another pill. RN N separated the digoxin from the other medications in case it had to be held based on the resident's heart rate. The resident took the digoxin every other day and it was difficult to get the medication out of the cup. During interview on 9/12/19 at 4:50 P.M. the Director of Nursing (DON) said the following: -Staff should not touch medication with bare hands then administer the medication to a resident; -Staff should wash hands all the time; -Staff should wash hands before and after any care; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Staff should change gloves and wash hands after touching dirty items and before touching clean items; -He expected staff to perform tracheostomy care per the facility policy and in a sanitary way. 36219 41412