STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	**02/04/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	**3002 NORTH 18TH ST SAINT JOSEPH, MO 64505**

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 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** Based on interview and record review, the facility staff failed to check all employees for a federal indicator (a federal mark that denotes they have committed abuse/neglect and cannot work in a nursing home). This affected five of ten recently hired sampled staff. The facility census was 93. 1. Review of the employee personnel records showed staff did not check for federal indicators until 2/4/16 for: - The Maintenance Director, hired 8/7/15; - The Registered Dietitian (who spent two days a week in the facility), hired 12/1/15; - Dietary Staff A, hired 12/11/15; - The Administrator, hired 1/11/16; - Unit Manager A, hired 1/29/16. During an interview on 2/4/16, at 3:40 P.M., the Human Resource Manager (HRM) said she recently took over the role as the HRM and did not know she needed to check the certified nurse's aide (CNA) registry (to check for federal indications) for all staff. They checked the CNA registry only for CNAs. However; she learned on 2/4/16, all employees needed to be checked though the system, so she checked the five sampled staff who had not been checked prior to that day. She had not checked all the other staff who were not CNA in the facility. They had a third-party employee screening system they used, and she thought it checked for the federal indicators. During an interview on 2/18/16, at 3:05 P.M., the Screening Company Worker A said they could check the license status of a CNA. However, he/she could not verify they confirmed the staff did not have a federal indicator, and unless the facility specifically request a CNA license check; they did not perform the CNA license check.
F 0226 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** Based on record review and interview, the facility staff failed to ensure they conducted a complete criminal background check (CBC) when their CBC system did not show all convictions. This affected one of ten sampled staff and had the potential to affect all residents and staff. The facility census was 93. 1. Review of the CBC, dated 1/22/16, conducted by a third-party company showed Unit Manager (UM) A did not have any findings on his/her CBC. Review of the CBC, dated 1/27/16, conducted by the Family Care Safety Registry (FCSR) showed UM A a driving while intoxicated (DWI) violation. During an interview on 2/4/16, at 3:40 P.M., the Human Resource Manager said they did not check everyone's CBC against the FCSR, only those who had been registered and were in the system at the time of hire. They primarily used a third-party company to complete their CBC. She thought they received all violations regarding the CBC with their third-party company. She did not know why the third-party company showed no findings and the FCSR showed a charge, since they both appear to run through the Missouri Highway Patrol database.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff maintained each resident's dignity and privacy when staff did not close resident doors during personal care which allowed people in the hallway to hear details of the care staff provided for residents and the potential for unannounced visitors to enter the room during care. This affected three residents (Residents #24, #25 and #34). The facility census was 93. Review of the undated pamphlet, Resident Rights For Long-Term Care in Missouri, showed residents have the right to privacy in medical treatment and personal care and should be treated with consideration and respect, with full recognition of each resident's dignity and individuality. 1. Review of Resident #25's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/15/16, showed: - A brief interview for mental status (BIMS) score of 14, (a 13 - 15 score indicates cognitively intact); - [DIAGNOSES REDACTED]. - Dependence on staff for toileting, personal hygiene, bed mobility and transfers; - At risk for pressure ulcers. Review of the resident's current physician's orders [REDACTED]. - 3/17/16: Foley catheter; - 3/30/16: May flush Foley catheter with 60 milliliter (ml) sterile water as needed (PRN). During an interview on 3/30/16, at 11:30 A.M., Family Member (FM) A said: - The resident's urinary catheter did not drain properly this morning and the resident complained of pain. FM A pushed the call light but no one came and answered it. - Finally, the Director of Nurses (DON) walked into the room to ask if there was a problem, did not shut the door, and discussed the resident's pain and the catheter not draining correctly and left the room. - Licensed Practical Nurse (LPN) H walked into the room, did not shut the door, and worked on the catheter. - A couple weeks ago when the resident's catheter did not work properly, a nurse walked into the room to work on the catheter, left the door open, and left the privacy curtain half way open. He/she stood outside the door, could hear all that was said and what happened in the room while the nurse worked on the catheter. - When the nurse left the room, he/she complained to the nurse that the door was open, all that he/she could hear, and the

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) lack of privacy for the resident. Later, the nurse returned to the room and apologized that he/she did not close the door. - The resident's room was on the corner of a busy hall and anything said in the room, could be heard in the hallway. He/she has walked down the hallway, toward the room, and could hear a conversation between the resident and a visitor. During an interview on 3/30/16, at 4:35 P.M., LPN H said: - The resident had a catheter for [MEDICAL CONDITION] and complained of discomfort this morning; - He/she performed care on the catheter and did not give a reason for not shutting the door. During an interview on 3/31/16, at 11:10 A.M., LPN C said staff should pull the privacy curtain and shut the door during any kind of care. During an interview on 3/31/16, at 4:50 P.M., the resident said: - He/she did not want strangers in the hallway to hear what was going on in his/her room. - That's the whole point of having the door closed! 2. Review of Resident #34's admission MDS, dated [DATE], showed: -A brief interview for mental status (BIMS) score of 12 (a score of 8-12 indicates moderate cognitive impairment); -Required extensive assistance for bed mobility; -Frequently incontinent of bladder; -Always incontinent of bowel. Review of the resident's care plan, dated 2/21/16, showed the resident was incontinent of bowel and bladder and required complete perineal care after each incontinent episode. Observation on 3/30/16, at 10:40 A.M., showed Certified Nurse Aide (CNA) H provided care in the following manner: -Left the room door open; -Pulled the privacy curtain and window curtains; -Provided incontinent care which involved incontinence of fecal material; -During care, the CNA told the resident he/she had a bowel movement and was dirty. -The resident was unable to speak clearly. During an interview on 4/1/16, at 8:41 A.M., CNA H said: -To provide care to the residents they needed to close the room door and the curtains for their privacy. -On 3/31/16, while he/she provided care to the resident, he/she did not close the resident's door. - He/she did not have a reason why he/she did not close the door, but should have closed it prior to starting the resident's care. 3. Review of Resident #24's admission MDS, dated [DATE], showed: -A BIMS score of 7 (a score of 0-7 indicates severe cognitive impairment); -Requires extensive assistance with bed mobility; -Frequently incontinent of bladder; -Always continent of bowel. Review of the resident's care plan, dated 2/20/16, showed: -Had episodes of urinary incontinence; -Required complete perineal care and assistance with brief changes with incontinent episodes. Observation on 3/31/16, at 9:10 A.M., showed Certified Medication Technician (CMT) C and CMT D provided care in the following manner: -Pulled the privacy curtain and window shades, but left the resident's room door open; -Told the resident he/she had a bowel movement and they needed to clean him/her; -Provided incontinence care and applied a clean brief. During an interview on 3/31/16, at 2:25 P.M., both CMT C and CMT D said: -Staff should pull the privacy curtain, make sure they closed the window shades and curtains and shut the room door when they provided personal care for residents to protect the resident's privacy. -They did not give a reason why they did not shut the resident's door during care this morning. 4. During an interview on 3/31/16, at 4:45 P.M., the administrator said the facility did not have a policy related to resident privacy. 5. During an interview on 3/31/16, at 4:55 P.M., the DON said staff should close the door, pull the privacy curtain, and be as discreet as possible during care. MO # 880
F 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to meet professional standards of care when they did not follow physician's orders [REDACTED].#2 every eight hours, did not properly transcribe telephone orders to the medication administration records (MAR) for Residents #23 and #26, which resulted in the residents receiving a lower dose of medications. The facility census was 93. 1. During an interview on 3/31/16, at 4:45 P.M., the Administrator said: - They did not have a policy regarding following physician's orders [REDACTED]. - They did not have a policy about transcriptions of medications from a telephone order to the MAR. 2. Review of the Resident #2's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/11/16, showed: - A brief interview for mental status (BIMS) score of 15, which indicated he/she was cognitively intact; - Limited assistance of one staff person for catheter assistance; - Not steady and needed staff assistance for walking, transferring, moving from a sitting to standing position, moving from surface-to-surface, and toileting; - Used an intermittent catheter (a straight catheter is inserted several times a day to empty the resident's bladder). Review of the resident's undated care plan showed: - On hospice care; - Rejected care at times; - Daily needs would be met; - At risk for urinary tract infections due to intermittent catheterization; - [MEDICAL CONDITION]; - The care plan did not address who would do the intermittent catheterizations or how often. Review of the March 2016, physician's orders [REDACTED]. - Straight catheter the resident every eight hours; - May straight catheter the resident every 12 hours as needed (PRN) for retention; - [DIAGNOSES REDACTED]. Review of the nurse's note, dated 3/24/16, at 1:36 A.M., showed staff documented to straight catheterize the resident every eight hours scheduled starting on 3/23/16, at 10:00 P.M. Review of the March 2016 Medication Administration Record [REDACTED].M., showed: - The resident received a straight catheterization every eight hours at 6:00 A.M., 2:00 P.M., and 10:00 P.M.; - The document showed the resident received his/her straight catheter on 3/30/16, at 2:00 P.M.; - The staff did not document the resident had not received his/her straight catheterization at 6:00 A.M., on 3/31/16. The MAR indicated [REDACTED]. - Staff did not document a reason why they did not straight catheterize the resident at 6:00 A.M. on 3/31/16. - The staff did not document they straight catheterized the resident on 3/31/16, at 2:00 P.M. (left blank on the MAR).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) - Staff did not document they straight catheterized the resident PRN anytime on 3/31/16. - The staff last documented they catheterized the resident on 3/30/16, at 10:00 P.M. Observation and interview on 3/30/16, at 3:17 P.M., showed: - The resident had his/her pants pulled down on his/her bed in his/her room. - The resident said he/she thought the surveyor was the nurse because he/she wanted to be straight catheterized. - The nurse should have come in around 2:00 P.M. and had not come in yet. - He/she felt pressure and some discomfort because he/she needs to go. - Oftentimes, staff were late with his/her catheterizations and he/she kept records of when they came into his/her room. - At 3:30 P.M., the straight catheterization had not been done yet. During an interview on 3/31/16, at 2:30 P.M., the resident said: - The nurse who did the straight catheterization put down he/she came into his/her room at 2:00 P.M. the day before (3/30/16). - Typically he/she caught that, because he/she knew that was incorrect; the nurse came later than that to assist him/her, but he/she could not remember the exact time. - He/she had not been straight catheterized that morning at 6:00 A.M., and had to have the day shift nurse do it for him/her because he/she really needed to urinate. - The night shift nurse should have catheterized him/her at 6:00 A.M. During an interview on 3/31/16, at 3:30 P.M., Licensed Practical Nurse (LPN) G said: - The resident should have his/her straight catheterization every eight hours. - He/she tried to get to the resident between 2:00 P.M. to 3:00 P.M. - He/she knew he/she did not straight catheterize the resident until after 3:00 P.M., on 3/30/16. - The resident said he/she had not been straight catheterized that morning (3/31/16). - He/she ran late on 3/30/16 and 3/31/16; he/she got to the resident about 2:30 P.M. on 3/31/16 (that day), and at that time the resident complained that he/she really needed to go because it had been about 16 hours since his/her last catheterization. During an interview on 3/31/16, at 4:34 P.M., LPN C said he/she did not think the resident had been straight catheterized that morning, but he/she did not know for sure. The resident may have been asleep, but he/she noticed the computer turned the order red (indicating it was late) at 10:00 A.M. that morning. The nurse who failed to administer the order worked on the night shift and did not put in a reason why it had not been done. During an interview on 4/1/16, at 1:46 P.M., the Director of Nursing (DON) said: - The resident should be straight catheterized based on his/her sensation of the urge to urinate. - The resident had the ability to tell staff when he/she needed to urinate and the staff only set up the catheter for the resident. - He expected staff to offer the resident to be catheterized one hour before and up to one hour after the time of the order. - Staff should not wait an hour after the ordered time to offer a catheterization to the resident. - The staff did not document outputs for the resident and used a straight catheterization sheet the resident kept in his/her room. Review of the straight catheter times sheet on 4/1/16, at 1:50 P.M., showed: - The resident received his/her catheterization on 3/30/16, at 2:00 P.M. - Staff last documented they catheterized the resident on 3/30/16, at 2:00 P.M. 3. Review of Resident #23's quarterly MDS, dated [DATE], showed: - A BIMS score of 15 (cognitively intact); - Limited assistance of one staff person for transfers, walking, and grooming; - Occasional pain at a level three on the pain scale (which ranks pain from one to ten, where ten is excruciating). Review of the resident's March 2016 POS showed: - [DIAGNOSES REDACTED]. - [MEDICATION NAME] (used for moderate to severe pain) 25 micrograms/hour (mcg/hr) apply patch topically every 72 hours-with a start date of 2/25/16 and a discontinued date of 3/28/16. - [MEDICATION NAME] 50 mcg/hr patch, apply patch topically every 72 hours-with an order date of 3/28/16, and a start date of 3/30/16; - [MEDICATION NAME] (used for nerve pain) 300 milligrams (mg) twice daily; - [MEDICATION NAME]/[MEDICATION NAME] (used for moderate to severe pain) 10/325 mg one tab three times a day. Review of the telephone order, dated 3/25/16, showed an order for [REDACTED]. Review of the resident's March 2016 MAR indicated [REDACTED] - [MEDICATION NAME] 25 mcg/hr patch on 3/24/16 and 3/27/16; - [MEDICATION NAME] 50 mcg/hr patch on 3/30/16. Review of the narcotic count sheet, dated 3/24/16 to 3/30/16, showed: - Staff signed out the resident received a 25 mcg/hr patch on 3/24/16; - Staff signed out the resident received a 50 mcg/hr patch on 3/25/16, 3/27/16, and 3/30/16. During an interview on 4/1/16, at 1:46 P.M., the DON said: - Staff did not get the order for the resident's 50 mcg/hr patch put into the computer until 3/28/16. - He thought the patch signed out on 3/25/16 was an error. - Their system had no way of backdating once staff gave the medication. - Staff needed to check the doses of the medications prior to administration. - The MAR indicated [REDACTED]. - If a telephone order had been given, the staff needed to put the new order into the computer. - He felt the medications had been given correctly, but they had a transcription error. 4. Review of Resident #26's admission MDS, dated [DATE], showed the resident: - Required extensive assistance of staff for all activities of daily living (ADL); - [DIAGNOSES REDACTED]. - Hospice care and on a scheduled pain medication regimen. Review of the resident's care plan, dated 3/20/16, showed: - Problem: At risk for pain related to a terminal condition; - Interventions included administer pain medications as ordered, observe for verbal and nonverbal indicators of pain, and evaluate pain using the 1 - 10 pain scale; - Problem: Due to decline, resident is admitted to Hospice for comfort measures related to the [DIAGNOSES REDACTED].>- Interventions include give medications as ordered and coordinate care with the hospice staff. Review of the physician's telephone order sheet (TOS) showed: - 3/28/16: Increase [MEDICATION NAME] (liquid [MEDICATION NAME]) to one milligram (ml) (no dosage per ml documented) every one hour PRN; - The nurse who received the order did not document the name of the ordering physician. - He/she did not document the name of the nurse who called the facility to give the order. Review of the POS [REDACTED] - Order date 3/10/16; start date 3/10/16: [MEDICATION NAME] (MS) 20 milligrams/milliliter (mg/ml) oral syringe, give 0.25 ml sublingually (SL) every hour PRN for pain/shortness of air (SOA), Discontinue Date: 3/13/16; - Order date 3/10/16, Start date 3/13/16: MS 20 mg/ml oral syringe, give 0.25 ml SL every hour PRN for pain; - Order date 3/10/16, Start date 3/13/16: MS 20 mg/ml oral syringe, give 0.25 ml SL every hour PRN for SOA, Discontinue Date: 3/28/16; - Order date 3/28/16, Start date: 3/28/16: MS 20 mg/ml oral syringe: give 1.0 ml SL every hour PRN for SOA. Review of the resident's controlled substance record showed: - 3/28/16: 8:30 A.M. 0.25 ml, given by LPN B; - 3/29/16: 3:00 P.M. 0.5 ml, given by LPN B, no order for this dose on the POS;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0281 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) - 3/30/16: 3:15 P.M. 0.25 ml given by LPN H, no order for this dose, discontinued on 3/28/16. Observation on 3/30/16, at 3:15 P.M., showed: - The resident in bed and complained of pain; - LPN H administered [MEDICATION NAME] 20mg/ml 0.25 ml SL. During an interview on 3/30/16, at 4:30 P.M., LPN H said: - He/she only saw the order for the MS 0.25 ml PRN; - There should not be two orders in the computer; - He/she felt terrible the resident did not get his/her full dose of pain medication. During an interview on 3/31/16, at 9:10 A.M., LPN C said: - Staff did not write the physician name on the TOS, but he/she thought it came from the Hospice physician; - No one discontinued the old MS order when they entered the new MS order into the computer. - He/she did not know why LPN B gave MS 0.5 ml on 3/29/16, as there was no order for that dosage. During a telephone interview on 3/31/16, at 10:50 A.M., the resident's Hospice Registered Nurse (HRN) said: - Staff called him/her on 3/28/16, for an increase in the resident's pain medication and he/she gave a verbal order from the Hospice medical director (HMD) for an increase in the pain medication to LPN B. - He/she did not give an order to titrate (the incremental increase in drug dosage to a level that provides the optimal therapeutic effect) the pain medication. During an interview on 4/1/16, at 8:37 A.M., LPN B said: - He/she wrote the order down incorrectly. The order should have read 0.25 mL up to 1.0 mL, not 1.0 mL. - He/she talked to another hospice nurse today, who said they could go up to 1.0 ml, but had not talked to the hospice nurse he/she contacted on 3/28/16. - He/she actually gave the resident 0.5 ml on 3/29/16. - He/she did a pain assessment to determine how much [MEDICATION NAME] he/she needed to give the resident in the nurse's notes. - When he/she took a telephone order he/she needed to include who gave the order to him/her, the physician, and the time and date of the order. During an interview on 3/31/16, at 4:55 P.M., the DON said: - Staff should document who they got the order from; - Staff should discontinue the old order when they enter a new order in the computer; - Staff should not give a dosage not ordered by the physician. During an interview on 4/1/16, at 8:40 A.M., the DON said he expected staff to document the reason they administered the dose they did when they gave a titration order.
F 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care to attain or maintain the highest practicable physical and mental well-being related to pain control for three out of 16 sampled residents (Residents #7, #12, and #13) when staff administered scheduled pain medications over an hour late, did not administer PRN (as needed) pain medications timely, and did not ensure crushed medications administered through a PEG tube (feeding tube surgically inserted into the stomach) were administered in a manner that ensured the resident received all of the medication. The facility census was 93. Review of the facility's undated policy for pain management showed: -The purpose is to provide guidelines for consistent evaluation, management and documentation of pain in order to provide maximum comfort and enhanced quality of life. -The policy did not address how soon a PRN pain medication should be administered once requested. Review of the undated policy related to oral and topical medication administration showed: -Take medications to the resident at the correct time. -Give time-critical scheduled medications at the exact time ordered (no later than 30 minutes before or after the scheduled dose). -Time-critical scheduled medications are those for which early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial suboptimal therapy or pharmacological effect (such as antibiotics, anti-coagulants, insulin and anti-convulsants). 1. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/4/15, showed: -No speech; -Long and short-term memory problems; -Severely impaired cognitive skills for decision-making; -Total dependence for all care; -Received scheduled pain medication; -Had a feeding tube; -[DIAGNOSES REDACTED]. Review of the resident's February 2016 physician order [REDACTED]. -[MEDICATION NAME]-[MEDICATION NAME] (a narcotic pain medication) 10 milligrams (mg)/325 mg, administer one tablet per PEG tube every six hours. Review of the resident's narcotic sign-out sheet for [MEDICATION NAME]-[MEDICATION NAME] 10 mg/325 mg showed staff documented they administered the medication on 1/30/16 at 12:15 A.M. and at 8:00 A.M., 7 hours and 45 minutes apart. Observation on 2/2/16, at 12:30, showed Licensed Practical Nurse (LPN) B administered the resident's [MEDICATION NAME]-[MEDICATION NAME] 10 mg/325 mg in the following manner: -Crushed the medication in a plastic sleeve, poured the crushed medication into a plastic medication cup, checked PEG tube placement, and attached a syringe to the end of the PEG tube; -Poured 50 milliliters (ml) of water into the syringe to flush the PEG tube; -Poured the dry, crushed pain medication directly into the syringe without mixing it with water; -Then poured the resident's nutritional feeding into the syringe followed by and additional 50 ml of water; -Residue from the crushed pain medication remained in the plastic medication cup and on the inside of the syringe. Review of the resident's narcotic sign-out sheet for [MEDICATION NAME]-[MEDICATION NAME] 10 mg/325 mg showed staff documented they administered the medication on 2/2/16, at 12:35 P.M. and at 8:00 P.M., 7 hours and 25 minutes apart. During an interview on 2/2/16, at 1:00 P.M., LPN B said: -He/she usually added enough water to liquefy medications before he/she administered them through a PEG tube, but got nervous because the surveyor watched him/her administer the medication. -He/she tried to administer medications within 30 minutes before or after the scheduled time, but had up to one hour before or after the scheduled time to give medications. -He/she looked at the narcotic sign-out sheet to verify the last time staff administered the resident's scheduled [MEDICATION NAME]-[MEDICATION NAME] and noted he/she documented that he/she administered it at 8:00 A.M. that morning. -Staff should call the resident's physician to notify him/her when staff did not administer the medication as ordered. 2. Review of Resident #12's admission MDS, dated [DATE], showed: -A brief interview for mental status (BIMS) score of 15 (13-15 indicated the resident as cognitively intact); -Had a surgical wound; -Received scheduled and PRN pain medications; -Received non-pharmacological pain interventions; -Had frequent pain and rated pain at an 8 on a scale of 1-10 (1 represents the least pain and 10 represents the most pain); -[DIAGNOSES REDACTED]. Review of the resident's physician order [REDACTED]. -[MEDICATION NAME] (a narcotic pain medication) 10-325 milligram (mg) tablet, give one every four hours PRN for pain;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0309 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) -[MEDICATION NAME](long-acting [MEDICATION NAME] sulfate, a narcotic pain medication) 15 mg twice a day. Review of the resident's care plan related to pain, dated 11/23/15, showed: -Experienced frequent pain related to a recent hip replacement and [MEDICAL CONDITION] joint disease; -Pain will be relieved within 45 minutes to one hour after taking pain medication; -Administer pain medication as ordered; -Monitor effectiveness of pain medication and notify physician if ineffective. Review of the resident's pain evaluation form, dated 1/17/16, showed: -Is not reluctant to verbalize or express indicators of pain; -Exhibited facial expressions as a possible indicator of pain; -Had current pain rated at a 9 (7-10=severe); -Pain interfered with ability to ambulate; -Pain was persistent; -Prescription medications were effective for pain relief; -Was satisfied with level of pain management. Review of the resident's January 2016 electronic Medication Administration Record [REDACTED] -Administer [MEDICATION NAME] mg twice a day at 7:00 A.M. and 7:00 P.M. -[DIAGNOSES REDACTED]. Review of the resident's [MEDICATION NAME] mg sign-out sheet for controlled substances for the month of January 2016 showed: -Take one [MEDICATION NAME] mg tablet every 12 hours; -Ten instances where staff administered the medication 13 hours 30 minutes to 14 hours 40 minutes between medication doses. During an interview on 2/3/16, at 11:15 A.M., the resident said: -He/she took [MEDICATION NAME] mg every 12 hours for excruciating joint pain, and took [MEDICATION NAME] every 4 hours PRN for pain. -He/she received the [MEDICATION NAME] various hours of the day and evening, and the medication did not control the pain as well when the administration times were not consistent. -At times, staff administered the [MEDICATION NAME] hours or more between doses. -He/she rarely received the PRN [MEDICATION NAME] within 15 minutes from the time he/she requested it. -Most of the time, it took 30 minutes to 1 hour for staff to bring his/her PRN pain medication. -He/she tried not to take pain medication more often than he/she had to, so when she asked staff for a PRN pain medication, it was because he/she needed it. -He/she should not have to wait an hour or more, or repeatedly ask staff for a PRN pain medication in order to receive it. 3. Review of Resident #13's quarterly MDS, dated [DATE], showed: -A BIMS score of 15; -Received scheduled and PRN pain medications; -Had almost constant pain that limited day-to-day activities; -Rated current pain as 3 on a 1-10 scale; -[DIAGNOSES REDACTED]. Review of the resident's care plan, last reviewed by facility staff on 12/28/15, showed: -Has constant pain in right lower extremity; -Administer pain medication as ordered by the physician; -Position foot on pillows when in the recliner; -Administer pain medications prior to activities of daily living to provide maximum control of pain and for comfort. Review of the resident's pain evaluation, dated 1/7/16, showed: -Had a documented end-stage disease with six or fewer months to live; -Was not reluctant to verbalize or express indicators of pain; -Had pain at the time of the assessment; -Prescription medication was effective; -Had frequent pain; -Rated pain to the right knee at a 6 on a 1-10 scale (4-6 =moderate pain). Review of the resident's nurses' notes, dated 1/13/16, showed staff wrote to start [MEDICATION NAME] (a medication used to treat [MEDICAL CONDITION] and nerve pain) 125 mg twice a day for [MEDICAL CONDITION], in addition to the scheduled [MEDICATION NAME]-[MEDICATION NAME] 7.5 mg/325 mg per 15 milliliters (ml) , 30 ml dose scheduled three times a day and every 4 hours PRN for pain. Review of the resident's February 2016 physician's orders [REDACTED].>-[MEDICATION NAME]-[MEDICATION NAME] 7.5 mg/325 mg per 15 ml, give 30 ml every 8 hours; -[MEDICATION NAME] (a narcotic pain medication absorbed through the skin) 50 micrograms (mcg) patch, apply one patch topically every three days and remove the old patch; -[MEDICATION NAME]-[MEDICATION NAME] 7.5 mg/325 mg per 15 ml, give 30 ml every 4 hours PRN pain; -[DIAGNOSES REDACTED]. During an interview on 2/3/16, at 3:00 P.M., the resident said: - It is next to impossible to get PRN pain medications, and has waited up to eight hours for a pain medication; - He/she asked for a pain medication in the early evening, but did not receive it until midnight; - He/she had to wait for pain medications frequently. During an interview on 2/4/16, at 5:10 P.M., Registered Nurse (RN) A said: -He/she tried to administer PRN pain medication to residents within ten minutes of their request for it. -30 minutes would be the longest a resident should have to wait unless something really pressing was occurring, and then he/she would tell someone to inform the resident that it would be longer than ten minutes, but that would be the exception. During an interview on 2/4/16, at 5:20 P.M., Licensed Practical Nurse (LPN) D said: -As a nurse, he/she tried to administer PRN pain medications at the time requested unless he/she was dealing with an emergency. -The PRN pain medication should be administered within 30 minutes of the request. -A resident shouldn't have to wait long periods for pain medication as the presence of pain might delay getting dressed or other care, or might trigger a behavior. 4. During an interview on 2/4/16, at 6:10 P.M., the Director of Clinical Operations (DCO) said: -Staff should administer PRN pain medications within 15 minutes of the time requested. -Staff should administer scheduled narcotic medications within 30 minutes before or after the scheduled time. -If the administration time of a scheduled narcotic significantly changed the time between doses, staff should contact the physician for direction before they administered the next dose.
F 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Assist those residents who need total help with eating/drinking, grooming and personal and oral hygiene.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide the necessary care and services to residents who were unable to carry out activities of daily living (ADLs) when they did not offer breakfast and eating assistance to one of 16 sampled residents (Resident #15), failed to provide baths as scheduled and according to the residents' preference for two sampled residents (Residents #12 and 14) and failed to provide complete incontinent care for two dependant additionally sampled residents (Resident # 20 and #21). The facility census was 93. Review of facility policy for Incontinent Care dated 8/1/12, showed: -Purpose: To ensure adequate skin care, control odor, and prevent skin damage; -Wash hands and apply non-sterile gloves;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) -Remove any soiled clothing or linens; -Wash, rinse and dry the buttocks area or use the peri-wipes according to the directions; -Wash hands and change gloves; -Assure the resident is comfortable. 1. Review of Resident #20's significant change in condition Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/21/15, showed: -[DIAGNOSES REDACTED]. -Unable to make decisions; -Totally dependant on staff for transfers, bathing, and personal hygiene; -Continent of bowel and bladder. Review of the resident's care plan, dated 1/11/16, showed: -At risk for skin breakdown; -Frequently incontinent of bladder; -Provide incontinent care after three incontinent episodes; -Dependant on staff due to [DIAGNOSES REDACTED]. Observation on 2/2/16, at 5:20 A.M. showed: -Certified Nurse Aide (CNA) A and CNA B assisted the resident to the toilet. -Removed the resident's urine filled brief; -CNA B wiped the resident's buttocks once with toilet paper which contained fecal material. -Neither CNA A or CNA B continued to wipe the resident's buttocks to assure the resident's buttocks contained no additional fecal material. -Neither CNA A or CNA B cleansed the resident's skin or perineal folds after removing the wet brief. -Staff put a clean brief on the resident and assisted him/her to the wheelchair. During an interview on 2/4/16 at 11:15 A.M. the MDS Coordinator said: -The resident's care plan should have read provide incontinent care after each incontinent episode; -Staff should provide incontinent care after each incontinent episode. 2. Review of Resident #21's admission MDS, dated [DATE], showed: -Unable to make decisions; -Totally dependant on staff for transfers, bathing, and personal hygiene; -Frequently incontinent of urine; always continent of bowel. Review of the resident's care plan, dated 1/20/16, showed: -Provide incontinent care as needed. Observation on 2/2/16, at 5:30 A.M., showed: -CNA A and CNA B assisted the resident to the toilet; - Removed the resident's brief which was filled with fecal material; -Staff wiped the buttocks once with toilet paper. -Neither CNA A or CNA B cleansed the resident's skin or perineal folds that came in contact with fecal material; -Staff put a brief on the resident and assisted him/her to the wheelchair. During an interview on 2/2/16, at 6:20 A.M., CNA A and CNA B said: -They did not have the supplies ready to provide perineal care and there were no disposable wipes in the residents' room. -They should have obtained disposable wipes to provide incontinent care. -Incontinent care should be provided after each incontinent episode; -They should have cleansed all areas of the body that came into contact with urine or feces. During an interview on 2/4/16, at 6:10 P.M., the Clinical Director of Operations (DCO) said: -Perineal care should be done after each incontinent episode. 3. Review of Resident #12's admission MDS, dated [DATE], showed: -A BIMS (brief interview for mental status) score of 15 (13-15 indicates is cognitively intact); -Required limited assistance for personal hygiene; -No bath occurred during that seven-day assessment period; -Continent of bladder and occasionally incontinent of bowel; -Had a surgical wound. Review of the resident's care plan, last updated 12/30/15, showed: -Bed bath only, as the resident could not get his/her wound wet in the shower; -Assist the resident as needed with bathing. Review of the undated 300 hall bath schedule showed staff scheduled the resident to receive a bath every Tuesday and Saturday during the first shift (day shift). Review of the resident's baths sheets, dated 12/17/15 through 2/3/16, showed staff provided bed baths to the resident on the following days: -12/17/15; -12/26/15, nine days since his/her last documented bath; -1/2/16, seven days since his/her last documented bath; -1/7/16, five days since his/her last documented bath; -1/20/16, thirteen days since his/her last documented bath; -1/25/16, five days since his/her last documented bath; -1/30/16, five days since his/her last documented bath; -As of 11:15 A.M. on 2/3/16, no staff had provided the resident with a bath for the current week, which started on 1/31/16; -Staff only provided bed baths to the resident twice a week, as directed by the bath schedule, only once during this time period, and one week received no baths. During an interview on 2/3/16, at 11:15 A.M., the resident said: -He/she did not receive bed baths like he/she should. -He/she had a leg wound and could not get it wet, so staff were to provide a bed bath. -It had been over a week since his/her last bath. -One CNA told him/her that he/she did not even know how to give a bed bath. -He/she could not stand very long, so could not do a bath at the sink in the bathroom and could not carry a basin of water to do one in his/her room. -He/she did the best he/she could, but could not do a full bath by his/herself. 4. Review of Resident #14's quarterly MDS, dated [DATE], showed: -A BIMS score of 14 (13-15 indicates is cognitively intact); -Required extensive assistance for personal hygiene; -Required total assistance for bathing; -Always incontinent of bowel and bladder. Review of the resident's care plan, last updated 1/1/16, showed: -Frequently incontinent of bowel and bladder; -Bathe at least twice weekly, or as desired; -Preferred bed baths before going to bed, at times; -Offer showers twice weekly. Review of the undated 200 hall bath schedule showed staff scheduled the resident to receive a bath/shower every Monday, Wednesday, Thursday and Friday on the first shift, and every Thursday on the second shift (evening). Review of the resident's bath sheets, dated 11/3/15 through 2/2/16, showed staff provided the resident with a bath or shower on the following days: -On 11/3/5, received a shower; -On 11/12/15, received a bed bath, nine days since the resident's last documented shower/bath;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0312 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) -On 11/20/15, the resident refused the bath/shower; eight days since the resident's last documented shower/bath; -On 11/27/15, received a bed bath, seven days since staff last documented they offered a bath/shower; -On 12/11/15, received a shower, 14 days since the resident's last documented bath/shower; -On 1/22/16, received a shower, 42 days since the resident's last documented bath/shower; -On 1/26/16, received a shower, four days since the resident's last documented bath/shower; -On 1/27/16, the resident refused a bath/shower because he/she had one the day before; -On 1/29/16, the resident refused a bath/shower because he/she had on the day before; -On 2/2/16, received a bed bath, four days since the resident's last documented bath/shower; -Staff documented the resident received three bed baths over approximately three months and only documented ten times that the resident received or was offered a bath or shower during this time. During an interview on 2/4/16, at 4:30 P.M., the resident said: -He/she thought he/she was scheduled to receive a bath or shower three times a week. -He/she did not know if he/she always received the three scheduled baths/showers each week. -He/she asked to receive a bed bath in the evening, before bed time, but never received one in the evening. -Staff told him/her there was not enough staff or time to provide a bed bath in the evening. During an interview on 2/4/16, at 4:50 P.M., CNA F said: -The day shift CNAs usually completed Resident #14's before the evening shift CNAs arrived. -The resident generally soaked him/herself with urine when he/she was incontinent, so it was easier to provide a shower rather than a bed bath. -He/she was not aware that the resident was ever scheduled for an evening shower or bath. During an interview on 2/4/16, at 4:25 P.M., CNA D said: -Staff kept bath/shower schedules in a notebook at the nurses' station. -Staff asked residents their bath preferences when they developed the schedule. During an interview on 2/4/16, at 6:10 P.M., the DCO said: -Residents should receive baths/showers according to the bath/shower schedule and their preferences. -If a resident wanted a bed bath in the evening, then staff should provide a bed bath in the evening. -Staff should complete a bath sheet for each bath/shower a resident received or refused. -Bath sheets should be an accurate representation of the baths/showers residents received. 5. Review of Resident #15's care plan dated 1/5/16, showed: - Staff needed to feed the resident his/her food; - Staff needed to encourage the resident to eat all meals; - If the resident did not like the foods, an alternative will be offered; - The resident did not want to be awaked if he/she was not up for breakfast. Review of the resident's significant change in condition MDS, dated [DATE], showed: - Short- and long-term memory problems; - Inattention and disorganized thinking; - Little interest/pleasure in doing things; - Totally dependent of two plus staff for transfers; - Extensive assistance of two plus staff to transfer in bed. - Extensive assistance of one staff for eating. Review of the meal intake logs, dated 1/28/16 to 2/4/16, showed the resident always ate zero percent of his/her breakfast. Observation on 2/4/16, at 7:35 A.M., showed: -Resident in bed resting with the lights out; -Resident's covered breakfast tray on cart in the hall. Observation on 2/4/16, at 8:02 A.M., showed: -Staff placed a plastic covering over the hall cart; -Staff removed the hall cart with the resident's breakfast tray. Observation on 2/4/16, at 9:30 A.M., showed the resident up an in his/her wheeled chair. During an interview on 2/3/16, at 3:05 P.M., Resident #1 said staff let Resident #15 sleep in. Typically, they did not bring him/her a hot meal. Sometimes the resident would moan at him/her between breakfast and lunch because he/she was hungry and he/she would feed him/her some yogurt. The staff did not offer the resident a cold breakfast tray. The resident required staff to feed him/her, not just drop off a tray. During an interview on 2/4/16, at 6:15 P.M., the DCO said Resident #15 liked to sleep in and that was in his/her care plan. She expected staff to offer and help assist the resident with breakfast when the resident woke up.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assure staff followed the facility policy for the prevention of skin breakdown and implement interventions to prevent the development of four pressure ulcers (a localized injury to the skin or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with sheer) for one of 16 sampled residents (Resident #7). The facility census was 93. Review of the facility's undated policy for skin care, Care System Guideline, showed: - Purpose: To provide a system for evaluation of skin at risk, identify individual intervention to address risk, and process for care of changes/disruption in skin integrity; - Pressure redistribution mattresses are in place; - If there is a decline in skin integrity, pressure redistribution surfaces will be reviewed for appropriateness; - Initiate a positioning schedule as necessary to meet individual needs and minimize concentrated pressure to the skin; - Designated nursing staff (DNS) or designee will be responsible to implement and monitor the skin integrity program; Review of the resident's admission Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 2/7/15, showed: - [DIAGNOSES REDACTED]. - Cognitive: Severely impaired, never or rarely made decisions; - Total dependence of two plus staff for all activities of daily living (ADLs) and bed mobility; - Impaired range of motion (ROM) of all upper and lower extremities; - Always incontinent of bowel; - Urinary catheter (a sterile tube inserted into the bladder to drain urine); - Skin Conditions: No pressure ulcers; - Resident at risk of developing pressure ulcers; - No healing pressure ulcers; - Scheduled pain medications; - Special treatments or programs: Hospice. - Care Area Assessment (CAA, indicates care area problems for the resident and triggers the need for a care plan) Summary identified pressure ulcers as a areas staff needed to develop a plan of care for. Review of Resident #7's quarterly MDS, dated [DATE], showed: - An unstagable deep tissue injury or unhealed pressure ulcer with eschar (black, brown, or tan tissue that adheres firmly to the wound bed). Review of the resident's care plan, problem onset dated 2/10/15, showed staff assessed the resident as at risk for pressure ulcers related to decreased mobility: - Approaches included a therapeutic low air loss mattress (a mattress that provides alternating pressure and is designed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 7) the prevention of pressure ulcers); - Reposition every two hours; - Assess skin during bed bath and report to nursing any redness or any skin integrity; - 11/10/15: Shearing to buttocks: treatment will be done as ordered; - 11/10/15: Deep tissue injury to left heel: treatment will be done as ordered; - 12/30/15: Treatment to blisters on left abdomen and left thigh as ordered; Resolved 1/19/16. Review of the computer charting of nurse's notes showed: - 12/18/15: Right heel blister, unstagable due to slough/eschar 100%; - Skin prep wipes to outer heel every day until healed; - No nursing notes entered from 1/21/16 through 2/2/16. Review of a Hospice Skin Issue Notification Sheet completed by a hospice Aide, dated 1/29/16, showed: - Frontal body map: perineal area circled, with red and bleeding area documented; - Posterior body map: sacral and buttocks area circled, with red and bleeding area documented. Review of Resident #7's February 2016, physician's orders [REDACTED]. - [DIAGNOSES REDACTED]. - Suprapubic urinary catheter (a sterile catheter inserted into the bladder through the lower abdominal wall), change as needed. During an interview on 2/1/16, at 9:30 A.M., while on the initial building tour, Licensed Practical Nurse (LPN) C said: - The resident was non-verbal and not able to take food or fluids orally; - Had a gastric tube (GT, a feeding tube inserted into the abdomen for administration of liquid nutritional supplements and medications); - Incontinent of bowel and had a suprapubic urinary catheter; - Sensitive skin, used a moisture barrier cream for skin protection, and had no skin breakdown. Observation on 2/1/16, at 9:30 A.M., showed the resident, with multiple, severe contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to all his/her joints, including both hands. He/she lay on his/her left side on a bed, which did not contain a therapeutic low air loss mattress, with the head of the bed (HOB) elevated to an approximately 45 degree angle. The resident did not have any type of supports or washcloths rolled in his/her hands to eliminate the worsening of his/her contractures. Observation on 2/2/16, at 6:15 A.M., showed the resident lay on his/her left side on a bed with no low air loss mattress in place and the HOB elevated to an approximately 45 degrees. A small, round cushion supported the resident's head under the left jaw. The resident did not have any type of supports or wash cloths rolled in his/her hands to prevent the worsening of his/her contractures. Observation on 2/2/16, at 6:45 A.M., showed the resident with no change of position. Observation on 2/2/16, at 6:50 showed Certified Nurse Aide (CNA) A entered the resident's room, emptied the resident's urinary catheter bag, did not change the resident's position, or provide any type of ADL care to him/her. Observation on 2/2/16, at 7:00 A.M., showed CMT A entered the resident's room, spoke to the resident's roommate, and did not change the resident's position in bed. Observation on 2/2/16, at 7:05 A.M., showed CNA C entered the resident's room, placed a pillow under the resident's roommate's head, and did not change the position of the resident. Observation on 2/2/16, at 7:20 A.M., showed MDS coordinator (MDSC) A and MDSC B entered the resident's room, handed a wash cloth to the resident's roommate to wash his/her face, and asked if the roommate wanted to get up for breakfast. MDSC A left the resident's room to get a mechanical lift, while MDSC B stayed in the resident's room to wait. MDSC B did not change the resident's position or provide any ADL care for the resident. The roommates's wheelchair sat, pushed against the resident's bed. MDSC B left the room after a few minutes. Observation on 2/2/16, at 7:30 A.M., showed MDSC A entered the resident's room with the mechanical lift, and assisted the Activity Director (AD) with perineal care on the resident's roommate. Staff did not provide any ADL care for the resident or change his/her position in the bed. Observation on 2/2/16, at 7:45 A.M., showed MDSC A and AD completed perineal care on the roommate, transferred the roommate with the mechanical lift to a wheelchair, and wheeled the roommate out of the room. Neither staff provided any care or repositioned the resident before leaving the room. Observation on 2/2/16, at 8:05 A.M., showed LPN B wheeled a medication cart to the doorway of the resident's room to administer his/her medications. The resident remained in the same position. At 8:15 A.M., LPN B entered the resident's room to administer medications, gave the resident's medications and nutritional supplement though his/her GT, and left the room at 8:30 A.M. LPN B left the room without providing any ADL care or changing the resident's position. Observation on 2/2/16, at 10:55 A.M., showed the resident wore a new, clean gown, but appeared to have been left in the same position. He/she remained on his/her left side with his/her head supported by the round support cushion. Observation on 2/2/16, at 11:30 A.M., showed the resident remained in the same position. During an interview on 2/2/16, at 11:30 A.M., CNA E said: - He/she did not know why the resident remained in the same position with his/her head to the left side with the round support in place under the chin. - Staff instructed him/her to put the round support in that position, but he/she did not know why. That's how staff told me to put it and he/she did not know why. Observation on 2/2/16, at 12:30 P.M., showed staff had changed the resident's position to the right side with his/her head turned to the right side. Review of the nurse's notes, dated 2/2/16, at 5:34 P.M., showed: - Resident noted by hospice to have been sweating, body warm to touch; - Hospice nurse here and temperature 101.3; - Orders received to increase [MEDICATION NAME] to every four hours as needed and [MEDICATION NAME] (an antibiotic) 500 mg daily for seven days; - Zinc cream apply to open areas on buttocks twice a day. Review of the resident's wound healing progress report, dated 2/2/16, showed: - Pressure ulcer: left buttock 2.40 x 1.50; staff did not document if they took any of the measurements in centimeters. - Excoriation/irritation left neck, under chin, dated 1/22/16: 4.0 x 10.50; - Excoriation/irritation left neck, under chin, dated 2/2/16: 5.0 x 8.0; - Pressure ulcer right buttock 3.70 x 2.60; - Pressure ulcer right outer buttock (1) 2.40 x 1.50, (2) 1.70 x 2.0 x 0.20; - Pressure ulcer right hip 3.0 x 1.80 x 0.20. - Staff did not document any stages of the pressure ulcers. Review of the nurse's notes, dated 2/3/16, at 1:52 A.M., showed: - Hospice assessed resident around 9:00 P.M. on 2/2/16; - Continue to monitor resident related to a decline; - No bowel movement since 1/28/16, administered suppository per orders; - Administered [MEDICATION NAME] per doctor orders due to shortness of breath, rapid breathing. Review of the nurse's notes, dated 2/3/16, at 3:45 A.M., showed: - Hospice nurse here on rounds; - New orders for one time dose of [MEDICATION NAME] (stool softener) suppository for no bowel movement for seven days. Observation on 2/3/16, at 2:45 P.M., showed the resident lying in bed with a new therapeutic low air loss mattress in place. During an interview on 2/3/16, at 2:55 P.M., the Director of Clinical Operations said: - Staff realized the resident had some skin breakdown; - Staff contacted hospice on 2/2/15, for a therapeutic low air loss mattress and hospice refused to send one because the resident did not qualify for one. - The facility found a low air loss mattress in the storage room and placed it on the resident's bed last night. During an interview on 2/3/16, at 4:00 P.M., the hospice registered nurse (RN) said:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 8) - He/she knew the facility spoke with hospice last night about obtaining a low air loss mattress for the resident. - The resident's bed had a low air loss mattress on it this morning. - They placed the resident on a six hour watch because of his/her decline. Observation on 2/3/16, at 4:45 P.M., showed LPN B and the Hospice RN entered the resident's room to assess the resident's skin and opened the resident's brief: - Four pressure wounds noted and both staff measured the wounds; - Open area on left upper buttock: 2.5 centimeters (cm.)(2.54 centimeters in one inch) Length (L) x 2.0 cm. Width (W); - Open area on left lower buttock: 4.25 cm. L x 3.25 cm. W; - Open area under right buttock: 2.5 cm. L x 2.0 cm. W; - Open area over right hip: 4.5 cm. x 3.0 cm. W. Review of the nurse's notes, dated 2/3/16, at 4:59 P.M., showed: - Hospice nurse here to see the resident; - Accompanied him/her with measuring and applying treatment; - All areas noted to have declined in size and all noted to be stage II; - Administrative nursing notified of above. Review of the resident's wound healing progress report, dated 2/3/16 showed: - Pressure ulcer left buttock 2.50 x 2.00 x 0.10; - Pressure ulcer right buttock (1) 4.25 x 3.25 x 0.10; - Pressure ulcer right buttock (2) 2.50 x 2.00 x 0.10; - Pressure ulcer right outer buttock: no documentation noted; - Pressure ulcer right hip 4.50 x 3.00 x 0.20; - Progress report did not specify if the wounds were measured in centimeters, and did not specify what stage of each pressure ulcer. Review of the resident's Braden Risk Assessment report (a scale used to assess a resident's level of risk for develop of pressure ulcers), dated 2/3/16 showed: - Assessment occasion: change in condition; - Risk score: 10 (high risk is 10 - 12). During an interview on 2/3/16, at 4:45 P.M., the hospice nurse said: - On Friday, 1/29/16, the resident did not have any skin breakdown. - The resident had red areas, but no actual open areas. - The resident was difficult to position due to contractures; - In May, 2015, the resident could shake his/her head and communicate. - On Tuesday, 2/2/16, the bath aide called and that was the first time he/she saw wounds. - On 2/2/16, the facility wanted a different mattress, he/she gave them a number of who to call, and they called to request one. Observation on 2/4/16, at 9:35 A.M., showed staff moved Resident #7 into a private room for end of life hospice care. Observation on 2/4/16, at 10:30 A.M., showed the resident with family at the bedside. He/she appeared to be resting comfortably on a therapeutic low air loss mattress, and pillows between contractured extremities. During an interview on 2/4/16, at 2:00 P.M., RN A said: - When he/she took care of the resident on Cedar hall, his/her bed had a air mattress and staff always padded him/her well with pillows; - The resident developed so many contractures that he/she could no longer sit in a wheelchair, as he/she would slide out and cause a shearing wound; - Staff tried to put rolled wash clothes into the resident's hands, but the contractures became so bad, if staff tried to move his/her fingers, he/she would yell out. - The facility did not have a primary wound nurse, only the nurse doing treatments that day. During an interview on 2/4/16, at 3:10 P.M., LPN D said: - On 2/1/16 and 2/2/16, the resident lay on the regular mattress with a bolster overlay provided by hospice. - On 2/2/16, the two MDS coordinators gave the resident a bath and found some red areas. - On 2/2/16, he/she assessed the resident, found four pressure ulcers (2 Stage I (intact skin with non-blanchable redness) and 2 Stage II (partial thickness loss of skin presenting as a shallow open ulcer), and called the hospice nurse. - The hospice nurse said he/she called for approval of an air mattress, it was declined because the hospice would have to initiate a treatment, have a decline, and the wounds get worse before an air mattress would be approved; - He/she informed the Director of Nursing (DON) of this conversation. - The facility provided their own air mattress that night. - He/she said the hospice nurse stopped the air mattress after the resident's heel wound healed. During an interview on 2/4/16, at 4:10 P.M., MDSC A and MDSC B coordinators said: - They went into the resident's room on 2/2/16, to turn and reposition him/her between 8:45 A.M. and 9:00 A.M., and found some open areas and wounds. - The resident's arms and legs were contractured and could not be straightened. - The resident's hips were even contracted. - The resident could not lie on his/her back from contracture/curvature, and could only lie on one side or the other. - The wounds were worse on the right side and both were Stage II. - They admitted the resident with wounds; he/she had an air mattress, and when the wounds healed, hospice removed the air mattress. During an interview on 2/4/16, at 6:05 P.M., the Director of Clinical Operations said: - The facility should provide an air mattress for a resident who staff assessed as at high risk for pressure ulcers. - The facility had a skin care policy for prevention of wounds and a wound module in place for treatment of [REDACTED]. - The facility's policy called for staff to keep a brief on a bed bound residents 24 hours a day. - Residents who were incontinent wore briefs.
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assure staff followed the facility's policy and procedure for urinary catheter (a sterile tube inserted into the bladder to drain urine) care for two of 16 sampled residents (Resident #2 and Resident #7), who had a history of [REDACTED]. The facility census was 93. Review of the facility's policy on Urinary Catheter Care, dated 2/1/12, showed:; - Purpose: To minimize the risk of catheter-associated UTI and its related problems; - With non-dominant hand, open the skin fold to expose the urethra. The skin fold is to remain open until rinsed. - With the dominant hand, wipe around the catheter at the insertion site using circular movements, wipe the catheter tubing moving away from the urethra at least four inches. - Turn the wash cloth and wipe down one side of the skin fold and then wipe the other side. - Keeping the skin fold open, rinse the wash cloth in clean water, and repeat these steps, always moving away from the urethra. - Use a towel to dry the skin folds. - The policy did not address emptying of the catheter bag. 1. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/2/15, showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) - [DIAGNOSES REDACTED]. - Total dependence of two plus staff for all activities of daily living (ADLs); - Always incontinent of bowel; - Urinary catheter (a sterile tube inserted into the bladder to drain urine). Review of the resident's care plan, problem onset dated 2/10/15, showed staff assessed the resident as at risk for UTIs related to his/her suprapubic catheter (a sterile catheter inserted into the bladder through the lower abdominal wall). Review of the resident's January 2016, physician's orders [REDACTED]. - [DIAGNOSES REDACTED]. - Suprapubic urinary catheter, change as needed, and catheter care every shift; - 1/8/16, [MEDICATION NAME] (an antibiotic for UTIs) for 7 days. Review of the resident's urinalysis (UA, a laboratory test done on urine to determine if an infection is present), dated 1/8/16, showed: - Leukocytes or white blood cells in urine (normal: negative); - Blood in the urine (normal: negative); - Bacteria in the urine (normal: none). Review of the resident's care plan dated, 1/8/16, showed urinary tract infection. Observation on 2/2/16, at 6:45 A.M., showed Certified Nurse Aide (CNA) A entered the resident's room to empty the resident's urinary catheter bag and did the following: - Washed his/her hands; - Placed a graduate (container to measure urine) on a paper towel; - Removed the urinary port from the sleeve; - Used an alcohol swab to clean the port; - Emptied the urine into the graduate; - Replaced the port back into the sleeve; - Did not clean it with alcohol. During an interview on 2/2/16, at 6:50 A.M., CNA A said: - He/she should have cleaned the port with alcohol before he/she placed it back into the sleeve. During an interview on 2/4/16, at 2:15 P.M., the Director of Nurses (DON), said: - Resident #7's urinary catheter was changed on 1/13/16, and the resident had a UTI in January. 2. Review of Resident #2's quarterly MDS, dated [DATE], showed: - Occasional incontinence and intermittent catheterization. Review of the resident's medical records, dated 10/16/15, showed a physician's orders [REDACTED]. Review of the resident's January 2016 POS showed: - [DIAGNOSES REDACTED]. - 7/29/15: May straight cath daily as needed for [MEDICAL CONDITION]; - 1/6/16: UA with culture and sensitivity (C&S) if appropriate related to thick, foul urine; - 1/9/16:[MEDICATION NAME] mg every day for three day; - 1/11/16: [MEDICATION NAME] 100 mg, one capsule daily at bedtime for [MEDICATION NAME] (medication to prevent infection); - 1/13/16: Foley catheter. Observation on 2/3/16, at 4:05 P.M., showed: - CNA G entered the resident's room to perform catheter care, washed his/her hands, and gathered supplies. - Positioned the resident on his/her back, with the resident's oxygen tubing lying between the resident's legs; - CNA G cleaned the outer skin folds, made two swipes of the inner skin folds; - Without changing gloves or washing his/her hands, grabbed the oxygen tubing with his/her soiled glove, moved the tubing away from the perineal area, and cleaned the urinary catheter at the urinary meatus (the urethral opening); - Cleaned the catheter with the soiled glove with three wipes. During an interview on 2/3/16, at 4:15 P.M., CNA G said: - He/she should not have touched the oxygen tubing with his/her clean glove, and then touched the catheter. During an interview on 2/4/16, at 6:05 P.M., the Director of Clinical Operations (DCO), said: - It is not acceptable to put a dirty catheter port back into the sleeve after emptying the catheter bag. - It is not acceptable to move the oxygen tubing and use the same soiled glove to clean the urinary catheter.
F 0322 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give proper treatment to residents with feeding tubes to prevent problems (such as aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal-pharyngeal ulcers) and help restore eating skills, if possible.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assure one of 16 sampled residents (Resident #7) who had a PEG tube (a feeding tube, surgically inserted into the stomach, used to administer nutrition and medications) received appropriate treatment and services when they failed to dissolve crushed medications in water prior to administration. The facility census was 93 with one other resident who had a feeding tube. Review of the undated policy provided by the facility related to PEG tube medication administration showed it did not address the administration of crushed medications. Review of an issue of the Institute for Safe Medication Practices dated 5/6/10, found at the website www.ismp.org/newsletters/acutecare/articles/ 506, showed: -Administration of medications through a feeding tube can be prone to errors. -Errors include preparing medications improperly, and/or administering a medication using improper administration techniques, which can lead to an occluded feeding tube, reduced drug effect or drug toxicity. -Oral medications intended to be taken by mouth must be prepared for enteral (directly into the stomach or intestine) administration. -Tablets must be crushed and diluted before administration. 1. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/4/15, showed: -No speech; -Total dependence for all care; -Had a feeding tube. Review of the resident's February 2016 physician order [REDACTED]. -[MEDICATION NAME]-[MEDICATION NAME] (a narcotic pain medication) 10 milligrams (mg)/325 mg, one tablet every six hours per PEG tube; -[MEDICATION NAME] (an anti-anxiety medication) 0.5 mg tablet, give one tablet per PEG tube twice a day; -[MEDICATION NAME] (an anti-depressant medication) 50 mg tablet, give one tablet per PEG tube daily. ** Give with 25 mg to equal 75 mg; -[MEDICATION NAME] 25 mg tablet, give one tablet per PEG tube daily. ** Give with 50 mg. to equal 75 mg. Observation on 2/2/16, at 8:15 A.M., showed Licensed Practical Nurse (LPN) B did the following: - Placed the resident's medications on top of the medication cart, crushed the resident's tablet medications in small plastic bags, dumped the medications into separate medication cups, entered the resident's room and set the medication cups on the resident's bed side table; - Did not mix the medications in the med cups with any water to dissolve the medications before administration; - Attached a syringe to the end of the PEG tube, injected air into the syringe, and listened with his/her stethoscope to verify the tube's placement in the stomach;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0322 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 10) - LPN B picked up one of the medication cups of a crushed tablet, dumped the contents with chunky pieces directly into the syringe, dumped a small amount of water, swished it around, let it drain into the stomach, and medication residue remained in the medication cup; - Picked up a second medication cup of a crushed tablet, dumped it directly into the syringe, dumped a small amount of water, swished it around, let it drain into the stomach, and medication residue remained in the medication cup; - LPN B repeated this same procedure with a third crushed tablet medication, flushed with some water, and left the room. Observation on 2/2/16, at 12:30 P.M., showed LPN B administered the resident's [MEDICATION NAME]-[MEDICATION NAME] tablet in the following manner: -Removed the medication card from the narcotic box; -Checked the medication label with the electronic Medication Administration Record [REDACTED] -Poured the medication into a plastic sleeve, crushed it, then poured it back into the medication cup; -Obtained supplies for medication administration, including 100 milliliters (ml) of water; -Checked placement of the PEG tube, placed a syringe in the end of the PEG tube, and poured 50 ml of water into the syringe and allowed it to flush the tube by gravity flow; -Poured the dry, crushed [MEDICATION NAME]-[MEDICATION NAME] tablet into the syringe, leaving medication residue adhered to the sides and bottom of the medication cup; -Poured 250 ml of a nutritional supplement into the syringe, then poured 50 ml of water into the syringe after the supplement infused; -Residue from the crushed [MEDICATION NAME]-[MEDICATION NAME] tablet remained along the inside of the syringe after the supplement infusion and the water flush. During an interview on 2/2/16, at 9:00 A.M., LPN B said he/she usually added enough water to the crushed medications to dissolve them before he/she administered them, but became nervous when a surveyor watched and did not add the water. During an interview on 2/4/16, at 6:10 P.M., the Director of Clinical Operations said staff should never crush medications and administer them directly into a PEG tube. They needed to be dissolved in water first
F 0323 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility staff failed to ensure they provided a safe environment free of potential accidents for all residents when staff failed to properly use techniques to reduce the possibility of accidents or injuries during a transfer belt transfer for one of three additionally sampled residents (Residents #20), failed to ensure they secured all potentially hazardous chemicals behind a locked door or cabinet, and failed to secure an injectable insulin pen when staff left it on top of a medication cart in the corridor for five minutes. The facility census was 93. 1. Review of the facility's policy on Transfer Belt, dated 4/14, showed: -Purpose: To assist the resident who is unsteady to transfer or walk safely; -Apply the transfer belt securely around the resident's waist; -Assist the resident to a standing position and assist the resident to pivot; -Remove the transfer belt. Review of Resident #20's significant change in status Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/21/15, showed: -Unable to make decisions; -Totally dependant on staff for transfers, bathing, and personal hygiene; -History of falls. Review of the resident's care plan, dated 1/11/16, showed: -Dependant on staff due to [DIAGNOSES REDACTED].>-At risk for falls; -Recent falls; -Staff assist with transfers using a transfer belt. Observation on 2/2/16, at 5:20 A.M., showed: - Certified Nurse Aide (CNA) A, CNA B and Licensed Practical Nurse (LPN) A entered the resident's room due to loud noises coming from the room. -The resident was attempting to get up unassisted from the bed. -CNA A informed LPN A that the resident's transfer belt could not be located. -LPN A instructed CNA A to assist him/her in transferring the resident without a transfer belt. -Staff stood on each side of the resident and held the resident's hands and assisted him/her to the wheelchair. -CNA A and CNA B then transferred the resident from the wheelchair to the toilet without a transfer belt holding the resident's hands; - Staff changed the resident's brief and then transferred him/her back to the wheelchair without a transfer belt. During an interview on 2/2/16, at 6:20 A.M., CNA A and CNA B said: -Staff should always use a gait or transfer belt when assisting an unsteady resident. During an interview on 2/2/16 at 8:00 A.M., LPN A said: -They knew the resident was a fall risk. -He/she did not want the resident to have an incontinent episode and thought staff should transfer the resident without the transfer belt. -He/she should have had staff obtain a transfer belt from another resident to safely transfer the resident. During an interview on 2/4/16, at 6:10 P.M., the Clinical Director of Operations (DCO) said: -Staff should never transfer a resident without using a transfer or gait belt. 2. Review of the Chemical storage policy dated 8/1/12, showed if possible, doors will have locks for security purposes. Observation on 2/2/16, at 11:12 A.M. and 12:25 P.M., and 2/3/16, at 4:40 P.M., showed five jugs of virucide/fungicide Cid-AL II (a disinfective used to kill a wide spectrum of organisms) stored in an unlocked storage room on the 100 hall. The label read Danger Keep out of the reach of children. The room also contained five containers of disinfectant wipes with the warning label Hazardous to humans and domestic animals. The staff kept mechanical lifts stored in the room. During an interview on 2/4/16, at 6:15 P.M., the Clinical Director of Operations said she knew staff stored the chemicals in the storage room on the 100 hall. The lifts should not be stored in that room and the door needed to remain locked at all times when staff were not in the room. 3. Review of the packaging label for Atropine Sulfate Opthalmic solution (used to treat inflammatory conditions of the eye) showed: - Keep out of reach of children; - For use in eyes only. Review of the quarterly MDS dated [DATE], showed: - A Brief Interview for Mental Status score of 15 (15 to 13 mean cognitively intact); - The resident sometimes felt bad about himself/herself. Observation on 2/1/16, at 4:20 P.M., showed: - LPN E wheeled a medication cart in 100 hallway and walked away. - A Novolog Flex Pen (insulin pen) sat on top of the medication cart with a resident's name clearly written on it. - A maintenance man and CNA walked by the medication cart. - Resident #1 walked up to the medication cart, stood next to it, and waited approximately two minutes for LPN E to return. - Resident #1 looked at items on top of the medication cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 11) - A period of approximately five minutes passed before LPN E returned to the medication cart. During an interview on 2/1/16, at 4:35 P.M., LPN E said: - He/she should not leave medications on top of the medication cart, but was called to the desk. Observation on 2/2/16, at 8:05 A.M., showed: - LPN B wheeled a medication cart to a resident's room to administer medications. - LPN B walked away from the medication cart. - Atropine Sulfate Opthalmic solution (used to treat inflammatory conditions of the eye) sat on top of the medication cart with a resident's name clearly written. - Multiple staff and residents walked by the unattended medication cart. - LPN B returned to the cart after several minutes. During an interview on 2/2/16, at 8:30 A.M., LPN B said: - He/she did not normally leave medications on top of the cart. - He/she thought the bottle was a testing solution for glucometer strips. During an interview on 2/4/16, at 6:05 P.M., the Director of Clinical Operations (DCO) said: - Staff should not leave medications on top of the medication cart and walk away.
F 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident gets a nutritional and well balanced diet, unless it is not possible to do so.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility staff failed to follow the facility's Resident Weight Monitoring policy. Staff failed to reweigh a resident when staff noticed a 21 pound variance, implement interventions recommended by the registered dietitian (RD), follow the resident's plan of care to offer him/her breakfast upon rising and notify the resident's physician when they determined the resident experienced a 21 pound weight loss in 30 days, or a 14.4% loss of body weight for one resident (Resident #15). The facility's census was 93. 1. Review of the facility's Resident Weight Monitoring policy, dated August 2012, showed: - Resident weights are recorded on admission and monitored at least monthly or as ordered by the physician to monitor the resident's condition. - If there is a three pound increase or decrease from the previous weight, the resident will be reweighed immediately. - Notification of a weight variance is to be made to the dietitian, physician, and family/responsible party. -Residents with a recent unplanned weight loss and/or a history of weight loss will be weighed weekly. -The threshold for significant unplanned weight loss/gain will be based on the following criteria: 1 month- 5% weight loss is significant; greater than 5% is severe weight loss. -The resident's care plan will be reviewed to assess for any special needs of the resident. Review of Resident #15's significant change in condition Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/18/16, showed: - Short- and long-term memory problems; - Inattention and disorganized thinking; - Little interest/pleasure in doing things; - Totally dependent of two plus staff for transfers; - Extensive assistance of two plus staff to transfer in bed; - Extensive assistance of one staff for eating; - No weight loss; - Weighed 144 pounds. Review of the resident's care plan, dated 1/5/16, showed: - Decline in condition due to end stage [MEDICAL CONDITION] (a progressive disease that destroys mental functions); - Potential risk for weight variance due to a pureed diet; - Other risk factors included severely impaired cognition, non-verbal, and agitation issues; - Unable to feed self due to severe cognitive impairment; - Staff needed to feed the resident his/her food; - Staff needed to encourage the resident to eat all meals; - The resident did not want to be awakened if he/she was not up for breakfast; - Staff needed to offer and/or feed the resident breakfast upon awakening; - Resident's weight will remain stable thru the next 90 day review period; - RD will review weights and make recommendations as needed due to weight variations. Review of the resident's Report of Monthly Weights showed staff recorded a weight of 145 pounds on 2/22/16 and did not indicate which scale staff used to weigh the resident. Review of an invoice provided by the facility, dated 3/1/16, showed the invoice pertained to the calibration of the wheelchair scales. Review of the resident's departmental notes, completed by dietary staff, showed: - 3/2/16 12:49 P.M.: Requests no breakfast tray at this time, likes to sleep in. Nursing staff will offer something to eat when he/she wakes up for the day. Review of the resident's Report of Monthly Weights showed staff recorded a weight of 124 pounds on 3/7/16 and did not indicate which scale staff used to weigh the resident. Review of the resident's departmental notes, completed by the RD, showed: - 3/15/16 at 4:31 P.M.: Weight of 124 lbs on 3/7/16; questionable requested resident to be re-weighed; - 3/23/16 at 11:51 A.M.: Resident did not want to be awakened for breakfast; resident to be offered breakfast upon awakening; drank better than he/she ate, would drink if beverage held to his/her mouth; - 3/23/16 at 12:56 P.M.: Made a recommendation for Med pass 2.0 (a supplemental shake to increase protein and calories) with medications three times daily. Review of the departmental notes from 3/15/16 through 3/31/16 showed staff did not document they reweighed the resident after the RD requested they reweigh him/her. Staff did not document they contacted the physician or the resident's responsible party about the resident's weight loss or about the RD's recommendation to begin providing a supplement for the resident. Review of the resident's Report of Monthly Weights showed staff recorded a weight of 122 pounds on 3/31/16 and did not indicate which scale staff used to weigh the resident. Review of a fax from the facility to the resident's physician, dated 3/31/16, showed: - Dietician recommends dietary supplement; - Med pass 2.0 30 cc three times daily, and weekly weights. Further review of the fax showed staff did not include the resident's current weight or indicate the resident had experienced a weight loss. Review of the meal intake logs, dated 3/25/16 to 3/31/16, showed staff documented the resident ate zero percent of his/her breakfast daily and staff notified the nurse. Staff documented the resident ate 75% -100% for lunch and 50%-100% for dinner during this week. Staff documented the resident refused all snacks with the exception of 3/26/16 at 5:14 P.M., 3/26/16 at 9:52 P.M., 3/28/16 at 10:32 A.M. and 3/30/16 at 8:20 P.M. Observation on 3/31/16, at 7:45 A.M., showed: - The resident lying in bed resting with the lights out; - His/her covered breakfast tray sat on cart in the hall. Observation on 3/31/16, at 8:45 A.M., showed: -Staff collected trays from numerous rooms; -Staff removed the hall cart with the resident's untouched breakfast tray.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0325 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 12) During an interview on 3/31/16 at 8:50 A.M., Certified Nurse Aide (CNA) K said: -He/she was the aide responsible for this resident's care. -The resident was sleeping when the hall trays were delivered to the hall and the resident did not eat breakfast. Observation on 3/31/16, showed: - At 9:00 A.M., the resident awake lying in bed with the head of the bed slightly raised; no food or fluids were available to the resident; - At 9:30 A.M., the resident awake lying in bed with the head of the bed slightly raised; no food or fluids were available to the resident; - At 10:18 A.M., staff assisted the resident from his/her bed to the wheelchair; staff did not offer the resident any breakfast or fluids; - At 10:25 A.M., the resident sat in his/her wheelchair as staff transported him/her to the shower room; - At 11:12 A.M., staff transported the resident back to his/her room after they gave him/her a shower; - At 11:20 A.M., two staff assisted the resident back to bed to receive a skin treatment; staff did not offer fluids or anything to eat. - At 11:45 A.M., Licensed Practical Nurse(LPN) I provided a skin treatment and did not offer him/her anything to eat or drink. - At 11:55 A.M., two staff assisted the resident from his/her bed to the wheelchair; staff did not offer him/her anything to eat or drink. - At 12:05 P.M., staff wheeled the resident from his/her room to the dining room for lunch. -At 12:30 P.M., staff assisted the resident with feeding him/her. During an interview on 3/31/16, at 2:00 P.M., CNA K said: - His/her shift began at 6:30 A.M., and he/she did not offer the resident a snack when the resident woke this morning or when he/she assisted the resident out of bed. - The resident preferred to not be woken up to eat breakfast. - The resident never ate breakfast. - He/she did not know he/she should offer and assist the resident breakfast upon awakening. During an interview on 3/31/16, at 3:10 P.M., LPN C said: - The resident's Family Member (FM) B voiced concern that the resident had lost weight and requested the resident be weighed (unknown date). - Nursing staff knew that on 2/22/16 the resident weighed 145 pounds and on 3/7/16 the weight recorded was 124 pounds. - He/she questioned the significant weight loss and thought nursing re-weighed the resident; however no one documented the second weight in the medical record. - Nursing staff should always document a resident's weight in the medical record. - Staff should offer the resident breakfast upon awakening. -The wheelchair scale had not been working properly for the last three months; - The scales had recently been recalibrated and the weight may not be accurate. - Generally speaking, staff could weigh residents and find as much as a five to 15 pound weight variance when they weighed residents. -He/she did not know of any resident other than Resident #15 who had a weight variance greater than 20 pounds. -The facility did not re-weigh all residents after they recalibrated the scale because they did not have a good base line weight. -The facility had two scales that staff used to obtain weights; one that weighed wheelchairs and a scale for residents who required a mechanical lift. - The facility had no system to identify which scale staff used to weigh the resident. Review of the resident's Care Giver Information Sheet (specific information that directs aides with residents' care needs), printed on 4/1/16, showed: - Do not wake for breakfast; - Offer the resident something to eat when he/she awakens. During an interview on 3/31/16, at 4:55 P.M., the Director of Nursing (DON) said: - Staff used the care giver information sheet as a tool for staff to direct care and was specific to each resident. - Staff should offer and assist the resident with breakfast upon awakening. -The resident's care plan should have been updated when staff identified the 21 pound variance. -The weight management policy should have been followed, and the physician and family should have been notified. -The RD did not communicate his/her recommendation on 3/23/16 to start the Med Pass 2.0. During an interview on 4/1/16, at 12:30 P.M., FM B said: -He/she visited the resident 3-5 times a week. -The resident should be offered food upon awakening in the morning. -He/she observed the resident's face becoming thinner. -He/she observed the resident's clavicle (located between the ribcage and the shoulder blade and connects the arm to the body) becoming more prominent. -The resident's wheelchair had been too small and since the recent weight loss the wheelchair now supported the resident's shoulders. -He/she informed the facility that the resident had lost weight in the last few months and he/she requested the resident be weighed. -He/she reviewed the resident's weights for the last few months and felt confident that the resident did not lose 20 pounds in a two week period, that the weight loss had been over the last two months. During an interview on 4/1/16, at 1:00 P.M., Resident #1 (the resident's roommate) said the resident still did not get breakfast in the mornings. The resident required staff to stay and feed the food to him/her. No staff ever stay with the resident and fed him/her breakfast or any other meals in his/her room. He/she has never heard staff offer the resident breakfast when they wake him/her up in the mornings.
F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a medication administration error rate of less than 5%. Facility staff made five errors out of 26 opportunities for error, resulting in an error rate of 19.2%. This affected one of 16 sampled residents (Resident #7) and one additional resident (Resident #22). The facility census was 93. Review of the facility's undated Administering Medications through a Metered Dose Inhaler policy showed: - Explain the procedure to the resident; - Shake inhaler well for 2 to 5 seconds; - Ask the resident to take a deep breath and exhale completely; - Place the mouthpiece in the mouth and instruct resident to close his/her lips to form a seal around the mouthpiece; - Firmly depress the mouthpiece against the medication canister to administer medication; - Instruct the resident to inhale deeply and hold for 10 seconds; - Remove the mouthpiece from the mouth and instruct the resident to exhale slowly through pursed lips; -Steroid inhalers may alter normal flora and lead to the development of fungal infections -Ask the resident to rinse mouth with warm water and spit out. 1. Review of Resident #22's physicians order sheet (POS), dated 2/16, showed: - an order for [REDACTED]. Observation on 2/1/16, at 3:34 P.M., showed Certified Medication Technician (CMT) B did the following: - Shook the inhaler for 2-5 seconds; - Handed the inhaler to the resident; - Did not give the resident any verbal instructions; - The resident inhaled and took one puff and held his/her breath for approximately 6 seconds;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 13) - He/she then shook the inhaler and took an additional puff from the inhaler; - The resident handed it back to CMT A. - CMT A did not ask resident to rinse his/her mouth. During an interview on 2/1/16, at 3:45 P.M., CMT B said: - He/she did not know [MEDICATION NAME] was a steroid inhaler; - He/she should have read the instructions printed on the label before administering the medication because it clearly reads rinse mouth after use; -He/she did not read the label until after the medication was administered. During an interview on 2/4/16, at 6:10 P.M., the Director Clinical of Operations (DCO) said: - She expected staff to instruct the resident to rinse his/her mouth after administering a steroid inhaler. 2. Review of the undated policy provided by the facility related to PEG tube (a feeding tube, surgically inserted into the stomach, used to administer nutrition and medications) medication administration showed it did not address the administration of crushed medications. Review of an issue of the Institute for Safe Medication Practices, dated May 6, 2010, and found at the website, www.ismp.org/newsletters/acutecare/articles/ 506, showed: -Administration of medications through a feeding tube can be prone to errors. -Errors include preparing medications improperly, and/or administering a medication using improper administration techniques, which can lead to an occluded feeding tube, reduced drug effect or drug toxicity. -Oral medications intended to be taken by mouth must be prepared for enteral (directly into the stomach or intestine) administration. -Tablets must be crushed and diluted before administration. 3. Review of Resident #7's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/4/15, showed: -No speech; -Total dependence for all care; -Had a feeding tube. Review of the resident's February 2016 physician order [REDACTED]. -[MEDICATION NAME]-[MEDICATION NAME] (a narcotic pain medication) 10 milligrams (mg)/325 mg, one tablet every six hours per PEG tube; -[MEDICATION NAME] (an anti-anxiety medication) 0.5 mg tablet, give one tablet per PEG tube twice a day; -[MEDICATION NAME] (an anti-depressant medication) 50 mg tablet, give one tablet per PEG tube daily. ** Give with 25 mg to equal 75 mg; -[MEDICATION NAME] 25 mg tablet, give one tablet per PEG tube daily. ** Give with 50 mg. to equal 75 mg. Observation on 2/2/16, at 8:15 A.M., showed Licensed Practical Nurse (LPN) B did the following: - Placed the resident's medications on top of the medication cart, crushed the resident's tablet medications in small plastic bags, dumped the medications into separate medication cups, entered the resident's room and set the medication cups on the resident's bed side table; - Did not mix the medications in the med cups with any water to dissolve the medications before administration; - Attached a syringe to the end of the PEG tube, injected air into the syringe, and listened with his/her stethoscope to verify the tube's placement in the stomach; - LPN B picked up one of the medication cups of a crushed tablet, dumped the contents with chunky pieces directly into the syringe, dumped a small amount of water, swished it around, let it drain into the stomach, and medication residue remained in the medication cup; - Picked up a second medication cup of a crushed tablet, dumped it directly into the syringe, dumped a small amount of water, swished it around, let it drain into the stomach, and medication residue remained in the medication cup; - LPN B repeated this same procedure with a third crushed tablet medication, flushed with some water, and left the room. Observation on 2/2/16, at 12:30 P.M., showed LPN B administered the resident's [MEDICATION NAME]-[MEDICATION NAME] tablet in the following manner: -Removed the medication card from the narcotic box; -Checked the medication label with the electronic Medication Administration Record [REDACTED] -Poured the medication into a plastic sleeve, crushed it, then poured it back in to the medication cup; -Obtained supplies for medication administration, including 100 milliliters (ml) of water; -Checked placement of the PEG tube, placed a syringe in the end of the PEG tube, and poured 50 ml of water into the syringe and allowed it to flush the tube by gravity flow; -Poured the dry, crushed [MEDICATION NAME]-[MEDICATION NAME] tablet into the syringe, leaving medication residue adhered to the sides and bottom of the medication cup; -Poured 250 ml of a nutritional supplement into the syringe, then poured 50 ml of water into the syringe after the supplement infused; -Residue from the crushed [MEDICATION NAME]-[MEDICATION NAME] tablet remained along the inside of the syringe after the supplement infusion and the water flush. During an interview on 2/2/16, at 9:00 A.M., LPN B said he/she usually added enough water to the crushed medications to dissolve them before he/she administered them, but became nervous when a surveyor watched and did not add the water. During an interview on 2/4/16, at 6:10 P.M., the DCO said staff should never crush medications and administer them directly into a PEG tube. They need to be dissolved in water first.
F 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough nurses to care for every resident in a way that maximizes the resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided sufficient staffing to meet the needs of residents when staff did not provide straight catheterizations as ordered which affected one resident (Resident #2); did not provide pressure ulcer care as ordered which affected two residents (Resident #8 and #35); and did not provide showers or bathing per resident preference and for periods of seven days or more which affected two residents (Resident #36 and #37). The facility census was 99. The facility did not provide a policy related to staffing needs. The facility did not provide a policy related to Straight Catheterizations but did provide an undated Care and Removal of an Indwelling Catheter policy which showed: - Abdominal pain and distention, a sensation of incomplete emptying of urine, incontinence, constant dribbling of urine, and voiding small amounts which could indicate inadequate bladder emptying which require intervention. 1. Review of Resident #2's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 2/11/16 showed: - Intermittent catheterizations. - Occasionally incontinent of urine. - [DIAGNOSES REDACTED]. Review of a handwritten telephone order dated 3/8/16 showed: - Clarification: Straight catheterization every eight hours and as needed twice daily. Review of the April, 2016 physician's orders [REDACTED]. - [MEDICAL CONDITION] bladder (dysfunction (flaccid or spastic) caused by neurologic damage. Symptoms can include overflow incontinence, frequency, urgency, urge incontinence, and retention. Risk of serious complications such as recurrent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 14) infection or back flow of urine into the ureter is high). Review of the May, 2016 electronic treatment administration record (eTAR) showed: - Straight catheterization every eight hours at 6:00 A.M., 2:00 P.M. and 10:00 P.M. - Straight catheterization every 12 hours PRN (as needed). - Charting of N on the eTAR means not administered. - At 6:00 A.M., straight catheterization not administered (N) two out of 11 days, 5/6/16, and 5/9/16. - At 2:00 P.M., straight catheterization not administered (N) four out of 11 days, 5/3/16, 5/4/16, 5/7/16, and 5/8/16. - At 10:00 P.M., straight catheterizations not administered (N) one out of 11 days, 5/7/16. - The eTAR showed no PRN catheterizations performed. Review of the May, 2016 Administration Record summary sheet showed: - 5/3/16 and 5/4/16: 2:00 P.M., straight catheterization scheduled every eight hours, documentation not completed by responsible party as administered - 5/6/16: 6:00 A.M.: straight catheterization scheduled every eight hours, not done by night nurse. - 5/7/16: 2:00 P.M. and 10:00 P.M., straight catheterization scheduled every eight hours, documentation not completed by responsible party as administered. - 5/8/16: 2:00 P.M., straight catheterization scheduled every eight hours, documentation not completed by responsible party as administered. - 5/9/16: 6:00 A.M., straight catheterization scheduled every eight hours, documentation not completed by responsible party as administered. During an interview on 5/12/16 at 10:00 A.M., Licensed Practical Nurse (LPN) B said: - The eTAR showed the 6:00 A.M. catheterization on 5/6/16 was not done by the night shift nurse. - A red mark showed up in the blank space for 6:00 A.M. on 5/6/16. - He/she charted the N on eTAR to assure there were no red blanks on the eTAR to show the procedure was not documented by the night nurse. - By charting the N, the red mark is deleted. - He/she did not remember which nurse worked the night shift. - The night shift nurse should have charted on the eTAR if the procedure was performed. - LPN B performed a straight catheterization at 11:58 A.M. per the resident's request and 700 cc of urine returned. - He/she charted the 11:58 A.M. catheterization in the 2:00 P.M. slot and on the Administration Record summary sheet. - The 2:00 P.M. catheterization was not performed because he/she catheterized the resident at 11:58 A.M. During an interview on 5/12/16 at 11:25 A.M., LPN J said: - He/she worked the day shift on 5/9/16. - The straight catheterization should be performed every eight hours and was scheduled for 6:00 A.M., 2:00 P.M., and 10:00 P.M. - Staff could also straight catheterize the resident twice PRN. - The morning of 5/9/16, the night nurse reported he/she did not perform the catheterization at 6:00 A.M. as scheduled. - It was not uncommon for the 6:00 A.M. catheterization to not be done because this was during the time of shift change and a lot of activity happened. - He/she charted on the Administration Record summary on 5/9/16 straight catheterization at 6:00 A.M. not administered. - If the catheterization was not done, he/she would not chart it in the nurse's notes, only on the eTAR and Administration Record summary; he/she would not chart the reason the catheterization was not performed. During an interview on 5/12/16 at 11:30 A.M., LPN K said: - He/she worked the night shift on 5/9/16 and did not remember if he/she performed the straight catheterization or not. - There was a high level of activity at 6:00 A.M. and at times not enough staff. - Night shift was responsible for performing the 6:00 A.M. catheterization. - LPN K said the resident would go out to smoke and be away from his/her room and this would contribute to the catheterization not getting done. - LPN K did not chart he/she did not perform the catheterization on 5/9/16. During an interview on 5/12/16 at 12:00 P.M. LPN N said: - He/she worked the night shift and did not get the 6:00 A.M. catheterization done some nights. - He/she did not work with the resident the weekend of 5/6/16 through 5/8/16. - There was a discrepancy as to who actually was responsible to perform the catheterization, the charge nurse or the treatment nurse. - He/she would report to the oncoming nurse if the catheterization was not done. - An N on the eTAR meant the procedure was not done. During an interview on 5/12/16 at 12:15 P.M., Registered Nurse (RN) B said: - He/she worked the night shift on 5/6/16 from 10:00 P.M. until 6:00 A.M. - The straight catheterizations were scheduled to be performed three times per day at 6:00 A.M., 2:00 P.M., and 10:00 P.M. - He/she passed medications between 4:00 A.M. and 6:00 A.M., the change of shift and counting narcotics took place at the time the catheterization was due, and the resident would smoke sometimes at 6:00 A.M. so the procedure would not get done. - If he/she did not get the procedure done at 6:00 A.M., he/she would often catheterize the resident later before he/she left the facility. - At times there was not enough staff to get this procedure done. During an interview on 5/12/16 at 2:45 P.M., LPN L said: - He/she worked with the resident on 5/7/16 from 6:00 P.M. until 11:00 P.M. - He/she did not know who should have performed the catheterization at 2:00 P.M. on 5/7/16 but the eTAR showed it was not performed. - He/she did not perform the 10:00 P.M. catheterization on 5/7/16 and reported this to the oncoming night nurse. - He/she was not sure who the night nurse was. - The eTAR showed the catheterization was not done on 5/7/16 at 10:00 P.M. During an interview on 5/12/16 at 4:00 P.M., LPN M said: - He/she worked on 5/7/16 from 6:00 A.M. until 6:00 P.M. and usually stayed later to finish charting. - He/she cared for 47 residents on his/her shift and the facility was understaffed. - He/she did not perform the straight catheterization at 2:00 P.M. on 5/7/16 but he/she should have. - There was no treatment nurse to help with treatments on that day. During an interview on 5/12/16 at 4:15 P.M., the resident said: - Staff did not perform the straight catheterizations every eight hours many times. - He/she kept a list of the dates, times, and nurses who performed the catheterizations. - Some of the nurses did not like that he/she kept a record. - The catheterizations should be done at 6:00 A.M., 2:00 P.M., and 10:00 P.M. - He/she could use the toilet but still needed to the catheterized because he/she did not empty his/her bladder. - Staff usually drained the bladder of 200 cc to 600 cc of urine each time. - The last few days 500 cc to 600 cc was been drained from his/her bladder. - He/she wanted staff to wake him/her at 6:00 A.M. to catheterize him/her but they did not at times. - He/she did smoke but usually would be in his/her room so staff could catheterize him/her at the scheduled times. - Staff put in an indwelling catheter in February, 2016. - Physician A was upset that the indwelling catheter was inserted and told staff to remove it. - Physician A gave staff orders to catheterize him/her three times a day. - The resident felt discomfort in the lower abdomen when the bladder became full and did not empty. - He/she dribbled or was incontinent of urine if the bladder was full. - He/she did not know why staff did not catheterize him/her three times a day but thought it was because there was not enough staff to get it done. During an interview on 5/12/16 at 4:45 P.M., the Interim Director of Nursing (DON) said:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 15) - She expected staff to follow physician's orders [REDACTED]. - If the treatment did not get done, staff should notify the physician. - The resident refused catheterizations at times. - The resident was a smoker and smoked several times a day and staff would not get the procedure done. - If the resident refused staff did not have to ask the resident again to do the catheterization. - She expected staff to chart why a catheterization was not performed. - Staff on the shift the catheterization was scheduled was responsible for performing the catheterization, but all staff should work as a team. - The charge nurse was responsible for monitoring the catheterizations to make sure they were performed. - The charge nurse should use the 24 hour report sheet to show if the catheterization was performed or not. During an interview on 5/16/16 at 9:00 A.M., Physician A's office RN said: - Physician A expected staff to follow his/her orders for catheterization of the resident. - The resident was cognitive and would know if staff did not catheterize him/her regularly. - The office RN said Physician A saw the resident on 2/22/16 and he/she had an indwelling urinary catheter in place. - Staff obtained the order for the indwelling catheter from the resident's primary care physician rather than calling Physician A, who treated the resident for a long period of time for urological issues. - He/she talked with staff on 2/22/16 and told them Physician A wanted the indwelling catheter removed because of the high risk of infection and gave an order to straight catheterize the resident two to four times a day and as needed. - The resident had a history of [REDACTED]. - If the resident's bladder was not drained frequently of residual urine, he/she could become septic (infection in the blood stream), have decreased kidney function, develop a UTI, and have discomfort in the lower abdomen. 2. Review of Resident #36's annual MDS dated [DATE], showed the resident was cognitively intact and that choosing showers were very important to him/her. Review of the residents care plan dated 7/4/2015, showed the resident was scheduled to receive showers twice a week on Tuesday evenings and Saturdays. Review of the shower records for Resident #36 dated 4/1/2016 through 5/12/2016 showed no showers: 4/1/2016 until 4/12/2016, 4/14/2016 until 4/20/2016, 4/21/2016 until 4/26/2016, 5/4/2016 until 5/10/2016. During an interview on 5/11/16 at 10:30 A.M , Resident #36 said he/she was supposed to get a shower on 5/7/2016 but did not receive one. He/she had waited up to 12 days in the past to get a shower. He/she asked an aide for a shower (couldn't remember aides name) but was told they couldn't fit (him/her) in. The resident said the facility was short staffed and became tearful about not receiving showers. He/she was told they were hiring new staff, but hadn't seen any yet. During an interview on 5/12/2016 at 9:30 A.M. the Administrator said residents should get two showers per week. During an interview on 5/12/2016 at 1:00 P.M., Certified Medication Technician A said often it was his/her job to shower the residents. He/she charted all the showers given on his/her shift. Sometimes other staff forgot to tell him/her about showers to chart and sometimes showers just didn't get done. For instance, they changed Resident #36's scheduled shower time from Tuesday evening to Wednesday day to make sure it would get done. During an interview on 5/12/2016 at 3:15 P.M., Licensed Practical Nurse (LPN) B said they had a designated shower aide when they were full staffed with five aides and a nurse on the 400/200 hall. Missed showers are scheduled for the next shift or at least by the next day. Residents would not go seven days without a shower unless it was their preference. During an interview on 5/12/2016 at 3:30 P.M., LPN L said he/she monitored the showers by signing the bottom of the shower sheets that were done. He/she worked 5/7/2016 on the 400/200 halls, where Resident #36 and Resident #37 lived and most of the scheduled showers that day did not get done due to lack of help. 3. Review of Resident #37 ' s annual MDS dated [DATE], showed the resident was cognitively intake and that scheduling showers were very important to him/her. Review of the residents care plan dated 3/27/2016 showed that he/she was scheduled to receive showers on Tuesdays and Saturdays. Review of the shower records for Resident #37 dated 4/1/2016 through 5/12/2016 showed no showers: 4/12/2016 until 4/19/2016, 4/20/2016 until 4/26/2016, 5/4/2016 until 5/10/2016. During an interview on 5/12/2016 at 4:20 P.M., Resident #37 said he/she had missed some showers. The facility was understaffed. When he/she first arrived last year he/she went 22 days without a shower. During an interview on 5/12/2016 at 4:30 P.M., the Director of Nursing said residents should receive a minimum of two showers per week unless the resident preferred less. The charge nurse assigned a certified nurse's aide (CNA) to do the scheduled showers and they knew which residents got showers. If staff did not get all the showers done, the residents were offered a shower on the next shift or the next day. The CNA should report to the charge nurse when showers don't get done or were refused. The charge nurse should report it in the nurses notes. Charge nurses had not reported that showers were not getting done. She did not recall that on 5/7/2016 that not all showers were completed. She said they did not have a shower policy. 4. Review of Resident #35's significant change MDS dated [DATE], showed: -[DIAGNOSES REDACTED]. -Occasionally incontinent of bowel and bladder; -Resident at risk of developing pressure ulcers (PU); -One Stage II PU (the outer layer of the skin and part of the underlying layer of the skin is damaged or lost) not present on prior assessment; -Extensive one staff assistant for all activities of daily living (ADLs) and bed mobility; Review of the resident's care plan, problem onset dated 3/18/16, showed unstageable ulcers on the right heel, right medial arch and on the left hip: -Approaches included staff to reposition at least every two hours; pressure relieving mattress and cushion on the wheelchair; provide wound care as ordered by the physician; daily observation of skin and notify the physician if the pressure ulcers worsen. Review of the resident's care giver information sheet, dated 5/12/16, showed the resident needs assistance of one with repositioning every two hours and as needed (PRN); tender lift and care (TLC) of two staff assist; and the resident is incontinent of bowel and bladder. Review of the resident's April 2016, POS showed: -Apply [MEDICATION NAME] (topical antibiotic that prevents bacteria from growing), hydrogel gauze (keeps wound bed moist) to wound bed on left hip. Apply skin prep to wound edges and apply cosmopor dressing (soft, absorbent adhesive dressing). Change the dressing daily and PRN with soiling; -Cleanse wound to right heel, apply [MEDICATION NAME] to wound bed, cover with hydrogel and cover with cosmopor daily and PRN for soiling; -Cleanse wound to right medial heel, apply mupirocin (topical antibiotic that prevents bacteria from growing), and cover with hydrogel and cosmopor daily and PRN for soiling. Review of the electronic treatment administration record (eTAR), dated 5/7/16 and 5/8/16 (Saturday and Sunday), showed none of the ordered wound treatments were administered. During a telephone interview on 5/11/16 at 4:00 P.M., LPN M said: -He/she unable to complete most of the treatments for his/her unit on 5/7/16 (Saturday), due to lack of staff; -He/she unable to complete wound treatment orders for Resident #35; -His/her floor should have a licensed nurse and a treatment nurse on the unit which rarely happens; -He/she received a new admission and was unable to get to all the treatments on Saturday. During an interview on 5/12/16 at 11:20 A.M., LPN L said: -He/she unable to complete the wound treatments over the weekend of 5/8/16 (Sunday), due to lack of staff and a treatment nurse; -He/she unable to complete the wound treatment orders for Resident #35;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0353 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 16) -There is not enough staff on the weekends to be able to complete all the wound treatments. During a telephone interview on 5/12/16 at 2:50 P.M., Certified Nurse Aide (CNA) P said: -He/she worked the hall with Resident #35 on 5/7/16 and 5/8/16 (Saturday and Sunday), and provided care for the resident; -The resident did not have a dressing on her left hip wound on either days over the weekend; - He/she unable to complete all his/her work assigned on the weekend due to not enough CNA's scheduled to work the floor. During an interview on 5/12/16 at 11:20 A.M., the facility family nurse practitioner (FNP) said: -He/she was notified by the contracted wound care nurse (NP) on 5/9/16, in the evening of Resident #35's decline in left hip wound and requested by the contracted wound care nurse (NP) check on the wound the next day, 5/10/16; -He/she should have been notified by the facility on 5/9/16, of a change in condition in resident #35's left hip wound condition. She was not notified of the residents change when she was in the facility on 5/9/16, from 3:00 P.M. to 7:00 P.M.; -Staff should follow physician orders [REDACTED]. -Staff should have notified him/her of the wound treatments not being completed over the weekend for Resident #35; -He/she ordered [MEDICATION NAME] due to redness surrounding the left hip wound edges, 100% yellow slough, and foul odor from the wound and to keep dressing the same until the NP visit on 5/13/16. During an interview on 5/12/16 at 2:50 P.M., contracted wound nurse (NP) said: -Resident #35 left hip wound was stable and improving when seen on 5/6/16; -He/she received a text message with a picture of resident's left hip wound and informed of the resident not receiving wound dressing changes over the weekend with the 5/6/16, dressing adhered to the residents bed sheets; -Resident's wound appeared to be worsened due to the treatment and dressing not being applied; -Staff should follow physician orders, complete daily dressing changes, and notify the physician if treatment is not completed and/or wound worsens; -He/she requested the resident's FNP to assess him/her on 5/10/16, until she visited on 5/13/16; -The dressing needed to be changed daily to let the [MEDICATION NAME] kill the bacteria and the hydrogel placed on the wound to keep the wound stable for debridement (removal of damaged tissue) at the next visit. 5. Review of Resident #8 MDS, dated [DATE], showed: -[DIAGNOSES REDACTED]. -Incontinent of bowel and bladder; -Resident at risk for PU; -Total dependence of two staff for all ADLs and bed mobility; -One Stage III PU (full thickness tissue loss. Under the skin fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of the tissue. May include tunneling) measuring 4 centimeters (cm) L (length) X 3 cm W (width). Review of the resident's care giver information sheet, dated 5/12/16, showed the resident needs assistance of one with ADLs and repositioning. Place disposable pad under his/her legs and [MEDICATION NAME] (elastic bandage) to both lower leg extremities. Resident is incontinent of bowel and bladder. Review of the resident's May 2016, POS showed: -Apply santyl to wound bed and a thin layer of [MEDICATION NAME] (ointment for minor skin irritations) to wound edges, ABD dressing, and [MEDICATION NAME] daily to right heel wound at 1:00 P.M. Review of the eTAR, dated 5/7/16 and 5/8/16, showed no treatments to the wound administered. During an interview on 5/11/16 at 3:45 P.M., CNA O said: -He/she gave Resident #8 a shower on 5/7/16, and requested LPN M to shower room to apply wound dressing to resident's right heel; -The resident waited for over twenty five minutes on the shower chair for LPN M to come apply the wound dressing; -LPN M told CNA O it would be awhile before he/she could get to the resident; -He/she requested the treatment cart keys from LPN M and retrieved the wound dressing supplies from the cart; -He/she applied santyl, gauze, ointment around the outside of the wounds, and applied an ABD dressing; -He/she should not have applied the wound dressing, but instead should have wrapped gauze around the wound until the nurse could do the treatment. During a telephone interview on 5/11/16 at 4:00 P.M., LPN M said: -He/she unable to complete most of the treatments for his/her unit on 5/7/16 (Saturday), due to lack of staff; -He/she unable to complete treatment orders for Resident #8; -His/her floor should have a licensed nurse and a treatment nurse on the unit which rarely happens; -He/she received a new admission and was unable to get to all the wound treatments; -He/she was unaware of CNA O completing the wound dressing change to Resident #8; -The treatment cart should be locked at all times and CNAs do not have access to the treatment cart; -He/she may have left the treatment cart unlocked when he/she left to admit a new resident; -Only licensed staff should perform wound treatments. During an interview on 5/12/16 at 11:20 A.M., LPN L said: -He/she unable to complete the treatments on 5/8/16 (Sunday), due to lack of staff and a treatment nurse; -He/she unable to complete the wound treatment orders for resident #8; -There is not enough staff on the weekends to be able to complete all the treatments. During an interview on 5/11/16 at 11:50 A.M., the WN said: -CNA O informed the WN that he/she had applied a wound treatment and dressing to resident # 8 over the weekend due to the nurse not being available. During an interview on 5/12/16 at 11:20 A.M., the facility family nurse practitioner (FNP) said: -Staff should follow physician orders [REDACTED]. -Staff should have notified her of the wound treatments not being completed over the weekend for Resident #8. During an interview on 5/12/16 at 4:45 P.M., the director of nursing (DON) said: -Staff should follow all physician orders, notify the physician if orders are not followed and a change in the residents' condition or wound; -Staff should not leave their shift until all the work and tasks are completed including wound treatments; -Ordered daily dressing changes should be on the resident at all times accept for showers within a 15 to 30 minute window. MO 9
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Store, cook, and serve food in a safe and clean way** Based on observation, interview, and record review, the facility staff failed to ensure they served resident's hall trays at the correct temperature when the hot food temperatures measured below 120 degrees Fahrenheit (°F). This had the potential to affect all residents who received a hall tray. The facility census was 93. 1. Review of the minimum temperature at the point of service policy, dated 8/1/12, showed hot food needed to be at least 120 °F when residents received their trays. During an interview on 2/2/16, at 7:00 A.M., the Dietary Manager (DM) said they could have up to a quarter to a third of the residents in the facility who received a room tray during meals. Review of the menu, dated 2/3/16, showed the residents needed to receive sliced ham, macaroni and cheese, and crumb top Brussels' sprouts. During a group interview on 2/3/16, at 9:30 A.M., eight residents said they received room trays. The hot foods had a cool temperature when they received their room trays. The other residents in the group said they received trays in the dining room and they did not have a problem with the food temperatures in the dining room at the time of the interview. Review of the temperature logs for the evening meal dated 2/3/16, showed the ham had a temperature of 187.9 °F when staff put it onto the steam table. Observation on 2/3/15, showed: - At 4:50 P.M., dietary staff started to fill the trays on the high boy (an unheated cart with racks used to transport room trays).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	3002 NORTH 18TH ST SAINT JOSEPH, MO 64505

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 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 17) - At 5:00 P.M., the high boy left the dining room. - Three staff distributed out the ten trays on the high boy to the residents. - At 5:07 P.M. the test tray ham had a temperature of 115 °F. - At 5:12 P.M., the food on the steam table had a temperature of 146 °F. During an interview on 2/3/16, at 5:12 P.M., the DM said said the room trays needed to be at a higher temperature at the time of service than the ham on 2/3/16. The food on the room trays should be closer to 140 °F at the time of service. The food temperatures needed to be at least 120 °F. They left off the steam table warm, but cooled quickly.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure staff followed proper infection control practices to prevent the spread of infection when staff failed to wash their hands between glove changes and failed to remove soiled gloves and wash their hands before they touched clean surfaces, which affected two additionally sampled residents (Residents #20 and #21), when staff wiped over an open wound with a soiled wet wipe, which affected one out of 16 sampled residents (Resident #11), when a staff with an arm/hand splint provided care without covering the splint or sanitizing it between resident care, and when staff failed to follow the Centers for Disease Control (CDC) guidelines related to screening residents for [DIAGNOSES REDACTED] (a communicable disease that especially affects the lungs), which affected two sampled residents (Residents #8 and 9). The facility census was 93. Review of the facility's policy for Handwashing/ Hand Hygiene, dated August 2014, showed: -This facility considers hand hygiene the primary means to prevent the spread of infections. -All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -Wash hands with soap and water when hands are visibly soiled. -Use an alcohol-based hand rub containing at least 62% alcohol, or soap and water before and after direct contact with residents, before preparing or handling medications, before and after assisting with meals, before or after handling an invasive device (e.g., urinary catheters, IV access sites), after contact with a resident's intact skin, after contact with blood or bodily fluids, and after removing gloves; -The use of gloves does not replace handwashing/hand hygiene. -Integration of glove use, along with routine hand hygiene, is recognized as the best practice for preventing healthcare-associated infections. 1. Review of Resident #20's significant change in condition Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 10/21/15, showed: -Unable to make decisions; -Totally dependant on staff for transfers, bathing and personal hygiene; -Continent of bowel and bladder. Review of the resident's care plan, dated 1/11/16, showed: -At risk for skin breakdown; -Frequently incontinent of bladder; -Provide incontinent care after three incontinent episodes. Observation on 2/2/16, at 5:20 A.M., showed Certified Nurse Aide (CNA) A and CNA B provided care in the following manner as they assisted the resident from the wheelchair to the toilet: - Washed their hands and put gloves on; - CNA B removed resident's wet brief; - CNA A and CNA B assisted the resident to stand; - CNA B wiped his/her buttocks with toilet paper that contained fecal material; - Without changing gloves or washing his/her hands, CNA B pulled the resident's pants up and touched the wheelchair as they assisted the resident into the wheelchair. -Both staff removed gloves and washed their hands. 2. Review of Resident # 21's admission MDS, dated [DATE], showed: -Unable to make decisions; -Totally dependant on staff for transfers, bathing and personal hygiene; -Frequently incontinent of urine always continent of bowel. Review of the resident's care plan, dated 1/20/16, showed: -Provide incontinent care as needed. Observation on 2/2/16, at 5:30 A.M., showed CNA A and CNA B provided care in the following manner as they assisted the resident from the wheelchair to the toilet: -Washed their hands and put on gloves; -CNA B removed the resident's soiled brief which contained fecal material; -Placed the soiled brief in the trash can and removed his/her gloves; -Without washing his/her hands, CNA B then assisted the resident with dressing. -CNA A and CNA B assisted the resident from the toilet to the wheelchair; -CNA A removed his/her gloves and both staff used hand sanitizer. 3. During an interview on 2/2/16, at 6:20 A.M., CNA A and CNA B said: -Staff should always wash their hands or use hand sanitizer before and after using gloves. -Staff should wash their hands when going from a dirty task to a clean task. -After providing perineal care, staff should remove their gloves and wash their hands. -Staff should not touch supplies with dirty gloves. During an interview on 2/4/16 at 6:10 P.M. the Clinical Director of Operations (DCO) said: -Staff should always wash their hands before applying and after removing gloves. -Staff should always wash their hands when going from a dirty task to a clean task. 4. Review of Resident #11's quarterly MDS, dated [DATE], showed: - [DIAGNOSES REDACTED]. - Extensive assistance of two plus staff for dressing, toilet, and personal hygiene. Review of the resident's current physician's orders [REDACTED]. -[DIAGNOSES REDACTED]. Observation on 2/2/16, at 7:30 A.M., showed: -The Activity Director (AD), who was also a CNA, entered the resident's room, performed perineal care on the resident's frontal areas, and rolled the resident to his/her right side. -The resident had a soiled dressing over an open area on the coccyx. -The AD removed the soiled dressing, wiped the rectum front to back and up over the open area with three separate wipes. During an interview on 2/4/16, at 4:35 P.M., the AD said: -He/she did not realize he/she wiped over the open wound on the resident's coccyx, and should not wipe over an open area. During an interview on 2/4/16, at 6:05 P.M., the Director of Clinical Operations said staff should not wipe over the rectum and over an open wound. 5. Observation on 2/2/16, at 7:05 A.M., showed CNA C wore a removable splint, made of synthetic material, on his/her left hand which covered his/her wrist, hand, and fingers, with the tips of the fingers extended out of the splint: -CNA C entered Resident #11's room, and without washing his/her hands or sanitizing the splint, grabbed a pillow, used both hands to pick up the resident's head, and placed the pillow under the resident's head. -He/she walked out of the resident's room, used alcohol to clean off the right hand, tips of left fingers, and did not clean the removable splint. -CNA C grabbed a breakfast tray with the soiled splint on one of his/her hands, entered another resident's room, pulled the bedside table to the bed, sat the tray on the table, touched the resident's cereal bowl, opened the cereal box, with both hands, and poured the cereal into the bowl.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265754	A. BUILDING _____ B. WING _____	**02/04/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF ST JOSEPH	**3002 NORTH 18TH ST SAINT JOSEPH, MO 64505**

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 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 18) -He/she used alcohol to clean off his/her right hand, tips of the left fingers, and did not clean the removable splint. -He/she then walked to the kitchen for jelly, returned to the same room, gave the jelly to the resident, and used alcohol to clean his/her right hand, tips of the left fingers, but did not clean the splint. -Grabbed another tray with both hands, entered another resident's room, pulled the bedside table to the bed, sat the tray down, raised the head of the bed, and began to set up the breakfast tray for the resident with both hands; -Touched the resident's knife, and tried to put jelly on the resident's toast with both hands without sanitizing the splint. During an interview on 2/4/16, at 4:20 P.M., CNA C said: -He/she should have put a glove over the splint. During an interview on 2/4/16, the DON said: -He/she expect staff to take the splint off for resident care and wash hands after care. During an interview on 2/4/16, at 6:05 P.M., the Director of Clinical Operations said: -It is not acceptable to wear a splint and go from resident to resident. -He/she preferred staff wear a larger glove over the splinted hand. 6. Review of the January 2005 Infection Control in Long-Term Care Facilities Manual guidelines for screening for [DIAGNOSES REDACTED] showed: -All residents new to long-term care who do not have documentation of a previous skin test reaction greater than 10 millimeters (mm) or a history of adequate treatment for [REDACTED]. -In addition, residents are to be evaluated, at least annually, to assure absence of signs and symptoms for TB. 7. Review of Resident #8's medical records showed staff admitted him/her to the facility on [DATE], from another long term care facility. Review of the resident's immunization record, provided by facility staff, showed no documentation of the required initial two-step TB skin test. 8. Review of Resident #9's medical records showed staff admitted him/her to the facility on [DATE]. Review of the resident's immunization record, provided by facility staff, showed the staff completed the required initial two-step TB skin test on 5/16/14 and 5/23/14, but showed no documentation of the additionally required annual TB skin test or further evaluation for signs and symptoms of TB. 9. During an interview on 2/4/16, at 5:05 P.M., MDS Coordinator A said: -He/she found no further documentation of TB skin tests or TB evaluations for Residents #8 and 9, other than the documentation provided. -Staff should do initial TB skin tests and annual TB evaluations after the initial TB skin tests. During an interview on 2/4/16, at 6:10 P.M., the DCO said: -Staff should complete a two-step TB skin test on residents initially, or document that the test was completed at a previous facility, then document an annual TB evaluation.