STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A389	A. BUILDING _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEBSTER HEALTH SERVICES NURSING FACILTY	70 MEDICAL PLAZA EUPORA, MS 39744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey at the facility from 1/13/20 to 1/16/20. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited deficiencies at F623, F625, F695, F759 and F842. The facility was licensed for 36 beds and had a census of 34 at the time of the survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		3/9/20

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

Electronically Signed | 02/28/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and record review, the facility failed to provide the resident or the resident's Representative Person (RP) written notification of a transfer or discharge to an acute care facility for two (2) of two (2) residents reviewed for transfer/discharge. Resident #19 and Resident #20.	F 623	. On January 16, 2020, a new easy-read notification document was developed to be used with all transfers and discharges. Bed Hold Notice is located on the back of this document to facilitate staff compliance current Bed Hold Policy. Present staff was reminded of policy on January 16, 2020.	

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F 623	Continued From page 3 Findings include: Resident #19 During an interview, on 01/13/2020 at 12:30 PM, Resident #19's daughter stated the resident had been sick and had been in the hospital. Review of Resident #19's medical record the resident was admitted to the hospital on 1/9/2020. An interview, with Registered Nurse (RN) #1 on 01/15/2020 at 4:30 PM, revealed the facility failed to have a notification of transfer signed by the family. RN #1 said the resident's family was present at the time of transfer, but no paperwork was signed. RN #1 stated this should be the responsibility of the nurse on duty at the time of transfer. RN #1 stated she should have followed up to be sure it was done. Resident #20 An interview, on 01/13/2020 at 3:20 PM, with Resident #20 revealed she had been in the hospital due to dizziness. Review of Resident #20's medical record revealed the resident was transferred to the hospital on 11/25/19. On 01/15/2020 at 9:18 AM, an interview with the Director of Nursing (DON) revealed the family was notified by phone or verbally of transfers, but was not aware of the regulation concerning a transfer form. On 01/15/2020 at 10:00 AM, an interview with the Administrator (ADM) revealed a transfer form was	F 623	*All residents have the potential to be affected by this deficient practice. *On January 16, 2020, a new easy-read notification document was developed to be used with all transfers and discharges. Bed Hold Notice is located on the back of the document. The document was immediately implemented on January, 16, 2020. Policy for Notice Requirements Before Transfer or Discharge of Resident or Therapeutic Leave was developed for further clarification on Janurary 16, 2020. Beginning on January 16, 2020, nursing staff was educated regarding new form and notification requirements before transfer/discharge or therapeutic leave. Emphasis was placed on considering Emergency Room visits within the same building as transfers, too, even though residents are not leaving the premises. Staff education was completed on all nursing staff, full-time, part-time and "as needed" employees by February 14, 2020. Compliance will be monitored monthly by reconciling Transfer/Discharge notices with Monthly Report of Transfers and Discharges sent to Ombudsman. Any deficiencies will be reported to the Performance Improvement Committee for recommendations.	

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F 623	Continued From page 4 not done for Resident #20 at the time of her transfer to acute care. The ADM stated she was not aware this was a requirement. She stated they did send the transfer information to the Ombudsman. The ADM stated she accepted responsibility because she should have known about it. On 01/16/2020 at 09:24 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed that she was not aware that transfer forms were supposed to be done.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		3/9/20

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F 625	Continued From page 5 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and record review, the facility failed to provide the resident or resident's Representative Person (RP) written notification of the bed hold policy upon transfer to an acute care facility for two (2) of two (2) residents reviewed for bed hold. Resident #19 and Resident #20. Findings include: Review of the facility's policy titled, "Bed Hold for Hospitalized or Therapeutic Leave Residents", with a review date of April 18, 2019, revealed all residents and their representatives are informed of guidelines related to Bed-hold notices. The facility policy revealed the family, surrogate, or representative are provided with written notification on admission and at the time of transfer. In cases of emergency transfer, notice "at the time of transfer" means that the family, surrogate, or representative are provided with written notification within 24 hours of the discharge. Resident #19 On 01/13/2020 at 12:30 PM, an interview with Resident #20's daughter revealed the resident had been sick with pneumonia and had been in the hospital. The daughter stated Resident #19 had been short of breath and was sent to the hospital for more care.	F 625	On January 16, 2020, a new easy-read notification document was developed to be used with all transfers and discharges. Bed Hold Notice is located on the back of this document to facilitate staff compliance with current Bed Hold Policy. Present staff was reeducated regarding existing Bed Hold policy on Januray 16, 2020. *All residents have the potential to be affected by this deficient practice. * The new document was immediately implemented on January 16, 2020. Policy entitled "Notice Requirements Before Transfer or Discharge of a Resident or Therapeutic Leave" was developed on 1/16/2020 for further clarification, and beginning on January 16, 2020, nursing staff was educated regarding new Transfer/Discharge and Bed Hold Notification form including notification requirements before transfer/discharge or therapeutic leave. This education was completed by February 14, 2020. All nursing staff was reeducated, beginning on January 16, 2020, regarding existing Bed Hold Policy, and emphasis was placed on considering Emergency Room	

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F 625	Continued From page 6 Review of Resident #19's medical record revealed the resident was admitted to the hospital on 1/9/2020 and was discharged on 1/13/2020. Chest x-ray and labs were done which confirmed Resident #19 was admitted for inpatient treatment. Resident #19 returned to the facility after discharge from the hospital. An interview with the Director of Nursing (DON), on 01/15/2020 at 3:35 PM, revealed the DON stated Resident #19 had an upper respiratory type cold prior to the hospital admission. The DON stated Licensed Practical Nurse (LPN) #1 had worked with Resident #19 during that time. An interview with LPN #1, on 01/15/2020 at 3:37 PM, revealed LPN #1 stated the resident had some slight upper respiratory symptoms the morning of the hospital admission, but was doing well and even participated in activities and ate lunch in the dining room. LPN #1 stated Resident #19 started feeling worse and coughing and was evaluated by the Nurse Practitioner (NP). A Chest x-ray and labs were ordered and the NP transferred Resident #19 to the inpatient area of the hospital for treatment. An interview, on 01/15/2020 at 3:40 PM, revealed LPN #1 stated Resident #19 returned to the facility after discharge from the hospital and is recovering. LPN #1 stated she is still weak, but has improvement in her alertness and appetite is noted. An interview with Registered Nurse (RN) #1, on 01/15/2020 at 4:30 PM, revealed the facility failed to have a bed hold and notification of transfer signed by the resident's family. RN #1 stated the	F 625	visits within the same building as transfers requiring notifications, too, even though residents are not leaving the premises. Staff education including full-time, part-time, and "as needed" nursing staff was completed by February 14, 2020. Compliance will be monitored monthly by reconciling Transfer/Discharge notice and Bed Hold Notification forms with Monthly Report of Transfers and Discharges sent to Ombudsman and with the Resident Sign-Out book that contains Therapeutic Leaves. Any deficiencies will be reported to the Performance Improvement Committee for recommendations.	

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F 625	Continued From page 7	F 625		

family was present at the time of the transfer, but no paperwork was signed. RN #1 stated this should be the responsibility of the nurse on duty at the time of transfer and she should follow up to be sure it is done. RN #1 stated she plans to work on this and make staff aware.

Resident #20

An interview, on 01/13/2020 at 3:20 PM, with Resident #20 revealed she had been the in the hospital due to dizziness.

Review of Resident #20's medical record revealed Resident #20 was sent to the hospital on 11/25/19.

An interview, on 01/15/2020 at 10:00 AM, with the Administrator (ADM), confirmed a bed hold form was not done on Resident #20 at the time of her transfer to acute care. She stated the Responsible Party was present at the time of the transfer.

An interview, on 1/16/2020 at 8:15 AM, with the ADM, revealed they have a bed hold form that they go over with the resident/responsible party on admission and in care plan meetings. The ADM stated the families were notified by phone when a resident was sent to the hospital. She stated getting the bed hold form signed just fell though the cracks, because they were not considering residents going to the Emergency Room or acute care a transfer, because they (the nursing home and the hospital) were in the same building. The ADM stated it was an oversite.

An interview, on 01/16/2020 at 8:20 AM, with Licensed Practical Nurse (LPN) #1, revealed she

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F 625	Continued From page 8 was aware of bed hold forms, but they had just forgot to do them.	F 625		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to store respiratory equipment in a manner to prevent the possibility of infection and/or contamination for two (2) of four (4) residents reviewed for respiratory treatments. Resident #27 and Resident #33. Findings include: Resident #27 On 01/13/2020 at 2:07 PM, an observation revealed Resident #27's nebulizer mask was hanging on the oxygen flow meter and not stored in a bag. Follow-up observations, on 01/14/2020 at 3:11 PM and 1/15/2020 at 10:40 AM, revealed Resident #27's oxygen cannula was hanging over the bedside table and the nebulizer mask was hanging on the oxygen flow meter. Neither were stored in bags.	F 695	*On 1/15/2020, staff immediately changed all oxygen nebulizer tubing and provided a protective bag to be used when tubing not in use by residents. On 1/15/2020, education was provided to cognitively intact residents requiring oxygen on the proper handling and storage of respiratory tubing and nebulizer apparatus. Present nursing staff was educated on the proper handling and storage of respiratory tubing on 1/15/2020. *All residents receiving oxygen or nebulizer treatments have the potential to be affected by this deficient practice. *In-service was conducted with all nursing staff on proper handling and storage of respiratory tubing on 1/15/2020. All	3/12/20

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F 695	Continued From page 9 On 01/15/2020 at 4:40 PM, an observation with the Director of Nursing (DON), revealed Resident #27 had her oxygen in use, but her nebulizer mask was hanging on the flow meter. On 01/15/2020 at 4:42 PM, an interview with the DON revealed the staff administering the treatments are responsible for storing the oxygen cannulas and masks. She stated they should be sealed in a plastic bag when not in use. The DON stated this could be a concern due to infection control issues and could be a concern for tripping and falls. Resident #33 During an observation and interview, on 01/13/2020 at 12:05 PM, Resident #33 stated she had been receiving respiratory treatments for Pneumonia several days ago. An observation at this time revealed Resident #33's nebulizer and tubing was hanging from the oxygen flowmeter in Resident #33's room. The tubing and nebulizer were not in a bag. An observation, on 01/14/2020 2:30 PM, revealed Resident #33's nebulizer and tubing continued to hang from the oxygen flowmeter without being in bag. An observation, on 01/15/20 at 2:58 PM, revealed Resident #33's nebulizer and tubing continued to hang from the flowmeter without being stored in bag.	F 695	nursing staff including full-time, part-time, and "as needed" employees were educated by 2/14/2020. On 1/15/2020, policy was reviewed and revised to specify: Oxygen tubing including nebulizer tubing, Continuous Positive Airway Pressure (CPAP)tubing, and any other oxygen device should be stored in separate protective bags when not in use. Bags are to be changed weekly beginning on 1/15/2020, dated beginning on 1/15/2020, and initialed when tubing and humidifiers or other respiratory devices are changed beginning on 1/15/2020. When the resident is not using the oxygen or nebulizer, but is still under an as per needed order, the device will be changed out and stored in its original package, attached to the resident□s flowmeter through a tiny opening in the original package. Once the device is in use, it will again be changed on a weekly basis. Staff has been educated beginning on 1/15/2020, regarding proper storage of oxygen tubing when not in use. Staff will assist residents with the handling of oxygen tubing when needed beginning on 1/15/2020. Cognitively intact residents who use oxygen and nebulizers that may choose to remove tubing themselves have been educated on 1/15/2020 regarding proper use and storage of tubing when not in use and are encouraged to ask staff for assistance. *Registered Nurses or clinical lead will	

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F 695	Continued From page 10	F 695	observe the handling and storage of oxygen tubing and other respiratory devices for two times per week for 8 weeks and then monthly thereafter beginning on 1/16/2020. Any observed deficiencies will be immediately corrected and reported to Performance Improvement Committee at least quarterly for additional follow-up.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to maintain a medication error rate of less than five percent (5%) as evidenced by failure to flush between the administration of six (6) medications via Resident #31's Percutaneous Endoscopic Gastrostomy (PEG) tube, for one of two (1 of 2) medication administration observations. There was 40 medication administration opportunities observed. The med error rate was 15 %. Findings include: Review of the facility's policy titled, "Medication Administration: Gastrostomy PEG Tube", dated December 2011, revealed: Gastro/PEG tube should be flushed with ten millimeters (ml) of water after each separate administration of medication.	F 759	*On 1/14/2020, Medical Doctor was notified of error for Resident #31 and no further orders were given. No adverse reactions observed. On 1/14/2020, Director of Nursing immediately reviewed Percutaneous Endoscopic Gastrostomy (PEG) protocol with present nursing staff. *Two residents have the potential to be affected by this deficient process. *Beginning on 1/14/2020, education was provided to all nursing staff regarding Percutaneous Endoscopic Gastrostomy (PEG) Tube medication administration. On 1/14/2020, Director of Nursing reviewed current policy with all nursing	3/12/20

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F 759	Continued From page 11 On 1/14/2020 at 8:27 AM, an observation revealed Licensed Practical Nurse (LPN) #2 failed to flush Resident #31's PEG tube between each medication administered via the PEG tube. LPN #2 administered six (6) medications via Resident #31's PEG tube. LPN #2 administered Alprazolam 0.25 milligrams (mg), Phenytoin 125 mg per 5 milliliters (ml), Ranidtidine 15 ml/ml give 10 ml, Benezepril 20 mg, Amolodipine 5 mg, and Atenolol 25 mg. The observation revealed each medication was mixed with water and given individually, but the PEG tube was not flushed with water between each medication. During an interview, on 1/14/2020 at 8:35 AM, LPN #2 stated she was aware of the policy to flush the PEG tube between each medication during medication administration. LPN #2 stated she was nervous and forgot to flush the PEG tube between each medication. LPN #2 stated she should have flushed the PEG tube with ten milliliters of water between each medication given to prevent complications.	F 759	staff present and with other nursing staff prior to next scheduled shifts. Education completed for for all nursing staff including full-time, part-time, and "as needed" staff on 2/14/2020. The medication error was reported at Performance Improvement Committee meeting on 02/26/2020. *Registered Nurses or clinical lead will observe Percutaneous Endoscopic Gastrostomy (PEG)Tube medication administration for two times per week for 8 weeks and then monthly thereafter beginning on 01/15/2020. Any observed deficiencies will be immediately corrected and reported to Performance Improvement Committee quarterly for additional follow-up.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		3/12/20

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	25A389	A. BUILDING _____ B. WING _____	01/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEBSTER HEALTH SERVICES NURSING FACILTY	70 MEDICAL PLAZA EUPORA, MS 39744

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F 842	Continued From page 12 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches	F 842		

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F 842	Continued From page 13 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to preserve the privacy of resident information during medication pass for two (2) of five (5) residents observed during medication pass. Resident #14 and Resident #31. Findings include: Review of the facility's policy titled, "Resident Rights: Privacy and Confidentiality", review date of April 8, 2019, revealed the rational was to provide guidelines to help preserve and protect a resident's confidentiality and privacy. It was the policy of Long Term Care that resident's confidentiality and privacy should be protected. The policy procedure revealed residents have the right to confidentiality for his/her personal and clinical records. Resident #14 An observation, on 1/14/2020 at 8:55 AM, during	F 842	*On 1/16/2020 all present licensed staff were instructed by Director of Nursing to ensure resident□s privacy is maintained during medication administration by locking computer screen when not at cart or when others have potential to view screen. *All residents have the potential to be affected by this deficient practice. *On 1/16/2020 the Information Technology Department was consulted regarding the need of screen locking option during medication pass. Locking option was shared on 1/16/2020 and instructions for screen locking option were posted on unit 1/16/2020. Nursing staff now has the ability to lock screen without losing data on 1/16/2020. Beginning on 1/16/2020, education was provided to all present nursing staff regarding locking options and protecting residents' privacy including	

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F 842	Continued From page 14 the medication pass observation revealed Licensed Practical Nurse (LPN) #3 left the computer screen up and open with pertinent resident information on Resident #14 visible while she was in the resident's room administering medications. During the remainder of the medication pass, the screen was tilted downward when the nurse was away from the cart, but resident information was not protected. Depending on the degree the screen was tilted down, the information remained on the screen or the screen blacked out and resident information readily reappeared when the screen was lifted. An interview, on 1/16/2020 at 11:48 AM, with LPN #3, confirmed she did not close the computer screen while she was in Resident #14's room. LPN #3 confirmed that anyone could have seen the resident's information. She stated she usually pushes the screen down to hide it but she did not think about the possibility of anyone being able to raise the screen and see the information. LPN #3 stated she guessed they needed to figure out how they could log off or sign out when giving medications. An interview, on 1/16/2020 at 12:00 PM, with the Administrator (ADM) confirmed the resident's information was not protected and data could have been viewed by people who should not be seeing it. The ADM stated this was a HIPAA (Health Insurance Portability and Accountability Act) issue. Resident #31 An observation, on 01/14/2020 at 8:27 AM, during the medication pass observation for Resident #31, revealed LPN #2 closed the computer	F 842	policy entitled "Resident Rights: Privacy and Confidentiality." Beginning on 1/16/2020, this information was shared with other nursing staff prior to their next scheduled shifts. All nursing staff including full-time, part-time, and "as needed" staff was educated by February 14, 2020. *Registered Nurses or clinical lead will observe medication administration to ensure patient's privacy is protected for two times per week for 8 weeks and then monthly thereafter beginning on 1/16/2020. Any observed deficiances will be immediately corrected and reported to Performance improvement Committee quarterly for additional follow-up.	

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F 842	Continued From page 15 screen approximately 50% and did not activate the privacy screen. Resident #31's pertinent and confidential information was visible while LPN #2 was away from the medication cart.	F 842		

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	25A389	A. BUILDING **01 - BUILDING 0101** B. WING _____	**01/16/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.7(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 02/27/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments ********** Survey conducted on 01/16/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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