STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175464	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES INDEPENDENCE	**1000 MULBERRY, PO BOX 627 INDEPENDENCE, KS 67301**

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 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents with 18 sampled for review. Based on interview and record review, the facility failed to complete a significant change in status Minimum Data Set, (MDS) for Resident (R)25 for two or more changes in activities of daily living in accordance with the Resident Assessment Instrument (RAI) manual, as required. Findings included: - Review of Resident (R)25's undated Physician Orders, documentation included [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE], documentation included the resident with the Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. The resident required extensive assistance of staff with walking, dressing, and locomotion. She required limited assistance with bed mobility, transfers, toilet use and personal hygiene. She was always continent of bowel and bladder. The quarterly MDS, dated [DATE] revealed changes which included the resident required extensive assistance of staff with bed mobility, transfers, and toilet use. She was totally dependent for locomotion. The resident was frequently incontinent of bowel and bladder. On 09/21/2020 at 02:05 PM, Administrative Nurse D, reported Administrative Nurse F was responsible for the completion of the MDS and would have to check with her to determine the reason the significant change MDS was not initiated with the residents decline in two or more areas. She stated the Resident Assessment Instrument (RAI) manual, provided guidance for the completion of the MDS. On 09/21/2020 at 02:51 PM, Administrative Nurse F confirmed the MDS coding as above indicated a change in more than two activities of daily living (ADLs) and verified staff should complete a significant change in status MDS, in accordance with the RAI manual, which the facility used for guidance in completing an MDS. The RAI manual, dated 10/2019, documented a significant change in status MDS is indicated when it is determined that a significant change (either improvement or decline) in a resident condition from his or her baseline has occurred as indicated by the comparison of the resident's current status to the most recent comprehensive assessment and any subsequent quarterly assessment and the resident's condition is not expected to return to baseline within two weeks. The facility failed to complete a significant change in status with two or more areas of decline in the residents ADLs annual MDS, dated [DATE], to the quarterly MDS, dated [DATE], as required.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents with 18 selected for review, including three reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to perform weekly skin assessments and prevent development of a stage two pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for Resident (R) 140. Findings included: - The entry Minimum Data Set (MDS), dated [DATE], revealed Resident (R)140 admitted from another nursing facility or swing bed on 09/01/20. The Hospice Comprehensive Assessment and Plan of Care Update Report, dated 08/26/20, for R140, included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE] was in progress. The care plan, dated 09/10/20, included a problem that R 140 was at risk for skin breakdown. Interventions included to provide skin assessments per protocol as indicated, assess skin and report any noted changes, monitor and report any changes while providing daily cares and/or assisting with bathing, and provide appropriate pressure relieving devices to her bed, wheelchair, and/or her personal sitting chairs. The resident was not on a turning/repositioning program. Furthermore, the care plan included a problem that R140 required staff assistance with activities of daily living (ADL's) related to physical limitations. R140 required limited assistance of one staff for transfers, however, the care plan lacked guidance for bed mobility. The hospice Visit Note Report dated 08/25/20,(prior to entry of R140 to the facility), revealed R140 had a stage two pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) to her coccyx (small triangular bone at the base of the spine). The onset date of the pressure ulcer was 08/01/20, and measured 2.7 centimeters (cm) by 2.6 cm by 0.2 cm. There was no exudate (fluid that leaks out of body vessels and tissues) and the skin color surrounding the wound was normal. The Clinical Health Review, dated 09/01/20, located in the electronic medical record (EMR), revealed R140 had a Braden (an assessment used to predict pressure ulcer risk) score of 16, indicating mild risk for skin breakdown. The interventions included repositioning, a low air loss mattress, and a wheelchair cushion. Furthermore, the assessment revealed R140 lacked any skin impairments. The review lacked an assessment regarding R140's cognitive function. The Certified Nurse Aide's (CNA's) Skin Observation, located in EMR, revealed from 09/01/20 through 09/17/20, there were no areas of skin concerns, that included scratched, red, discolored, torn, or open areas. A witness statement provided by the facility administrator, dated 09/06/20, by Licensed Nurse (LN) I, revealed on 09/01/20, when admitting R140, staff performed an initial skin assessment and revealed the resident had no skin impairments. R140 had a dressing on her tailbone, and there was no injury or impairment noted under the dressing. The resident reported she got wounds there A lot and used the dressing as a preventative measure. Furthermore, the statement revealed R140 had a wheelchair cushion and a low air loss air mattress for further preventative measures for recurrent tailbone wounds. Review of the EMR, from dates 09/01/20 through 09/15/20 lacked skin condition notes in the progress note section and lacked skin assessments under the assessment section. Review of the Certified Medication Aide (CMA) Medication Administration Record [REDACTED]. On 09/15/20 at 11:41 AM, R140 was fidgeting off of her buttocks in the recliner in her room. A cushion was in place to the recliner, however, the cushion was at the back rest and not in the seat of the recliner. On 09/15/20 at 11:42 AM, R140 reported that she had A bad sore to her coccyx, and hospice provided dressings and a mattress. Furthermore, she reported the cushion to her back in the recliner could be used to sit on, but it did not really help. On 09/16/20 at 03:32 PM, LN H revealed that staff should document skin assessments in the skin assessment section in the computer, under the assessment tab, and should be completed on admission, when the resident recieved baths, and daily. Furthermore, she revealed staff lacked a schedule when to complete a head to toe skin assessment on the residents and Administrative Nurse E was responsible for the skin assessments. On 09/16/20 at 03:37 PM, Administrative Nurse D, reported staff should complete skin weekly. On 09/16/20 at 04:03 PM, Administrative Nurse E, responsible for resident skin assessments, reported she was behind on the skin assessments. Skin assessments should be documented in a skin condition note under the progress note section of the EMR. Nurses should also document the skin assessments. The skin sheets were a new process the facility started, to communicate the resident's skin concerns. CNA's should complete the skin sheets when showers are completed. Administrative Nurse E verified the resident lacked skin sheets and reported staff should assess the resident's skin weekly. The facility failed to perform a weekly skin assessment after admission on 09/01/20 for R140. The Skin/Wound Condition Assessment, dated 09/16/20 at 07:24 PM, revealed R140 had a stage two pressure ulcer to her coccyx that measured 2 cm by 2 cm by 0.1 cm. The description of area in the assessment revealed R140 had an open wound to her coccyx. The wound was circular in shape and the wound bed was pale in color. There was no drainage. The assessment further indicated that R140 had a reoccurring wound to her coccyx, per her spouse, the previous facility where the resident resided in, and her hospice provider. The assessment documented the resident had preventative measures in place since her admission. On 09/17/20 at 10:51 AM, LN G

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

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

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) was unaware if R140 had a pressure ulcer to her coccyx when she admitted to the facility. On 09/17/20 at 12:03 PM, Administrative Staff A revealed the pressure area was found by administrative nurse D when they were assisting R140 with her shower Last evening and staff was unaware the resident had skin issues. The facility policy Wound Prevention and Management, dated 12/2018, revealed the facility would develop a system to review all residents at risk on a weekly basis. The Licensed Nurse would be responsible for weekly assessment of skin for all residents and document findings in the EMR skin condition note. The Director of Nursing or designee would be responsible to review the skin condition progress notes. The facility failed to perform weekly skin assessments to monitor/assess the condition of R140's skin after admission, to prevent a facility acquired stage two pressure ulcer from developing.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents, which included six residents sampled for respiratory care. Based on observation, interview, and record review the facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person centered care plan for six Residents (R)27 related to storage of Continuous Positive Air Pressure ([MEDICAL CONDITION]); R 15, R 5, R 14, and R 140, related to storage and tubing/mask change of nebulizer kit; and R 5, R 14, R 140 and R 10 related to storage and tubing/mask change of oxygen equipment. Findings included: - Review of Resident (R)27's undated Physician Orders, documentation included [DIAGNOSES REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE], documentation included the resident admitted date on 08/10/2020, with the Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact. Special treatments included non-invasive mechanical ventilator (Bi-PAP (bi-level positive airway pressure)/[MEDICAL CONDITION] (continuous positive airway pressure)). The care plan (CP), dated 08/19/2020, directed staff the resident with sleep apnea and used a [MEDICAL CONDITION]. The staff were to store the mask in a storage bin when not in use. On 09/14/2020 at 03:00 PM, the resident's [MEDICAL CONDITION] mask was laying on the floor with the tubing draped across the bedside table. The resident lacked a storage bag or bin available to store the resident's [MEDICAL CONDITION] mask, to prevent cross contamination and infection. The resident reported he had not had a container or bag for storing his [MEDICAL CONDITION] mask in a while. On 09/14/2020 at 05:44 PM, the resident's [MEDICAL CONDITION] mask was laying uncovered on the bedside table. Licensed Nurse (LN) I confirmed the mask was not stored properly and stated the [MEDICAL CONDITION] tube and mask should be stored in a bag. On 09/17/2020 at 10:49 AM, Certified Nurse Aide (CNA) LL stated the resident's individual needs and preferences are documented on the care plan. She reported respiratory equipment such as masks/tubing if not in use should be stored in a bag to prevent infection. CNA LL stated she checked for the proper storage of respiratory equipment when she enters a resident's room. On 09/17/2020 at 02:34 PM, LN G, stated the resident's individual needs were in the care plan. She reported the respiratory equipment such as tubing and bags are changed out weekly. LN G reported the staff should store the tubing and mask of respiratory equipment in a zip lock bag labeled with initials and staff should date the bag when changed. Masks should be stored in a bag when not in use to prevent infection. On 09/21/20 at 06:43 PM, Administrative Nurse D verified staff should change the tubing and bag for storage of respiratory equipment weekly and should store the mask when not in use to prevent infection. The facility policy Infection Management Process, dated 12/2019, documentation lacked address of care and/or storage of respiratory equipment tubing/mask. The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection consistent with standards of practice and person-centered care plan for this resident that required [MEDICAL CONDITION], related to storage of [MEDICAL CONDITION] mask when not in use. - Review of Resident (R)15's undated Physician Orders, documented [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE], documentation included the resident with the Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. He did not experience shortness of breath and did not use oxygen. The quarterly MDS, dated [DATE], revealed changes which included BIMS score of 12, indicating moderate cognitive impairment. He did receive oxygen. The care plan (CP), dated 08/06/2020, directed staff to change the nebulizer tubing, bag, and label the bag with a date when changed, once weekly, on Tuesdays. On 09/14/2020 at 05:25 PM, the resident's nebulizer tubing, dated 07/14/2020 was in a storage bag dated 06/23/2020. On 09/15/20 at 11:21 AM, the resident's nebulizer tubing, dated 07/14/2020 remained in a storage bag dated 06/23/2020. On 09/15/20 at 11:37 AM, Administrative Nurse D verified the above observation. On 09/15/2020 at 02:08 PM, Licensed Nurse G stated respiratory equipment tubing and bags should be changed and labeled with the date weekly, by the night shift. She reported that tubing and masks should be stored in a bag when not in use to prevent infection. On 09/17/2020 at 10:49 AM, Certified Nurse Aide (CNA) LL stated the resident's individual needs and preferences are documented on the care plan. She reported respiratory equipment tubing if not in use should be store in a bag to prevent infection. The nurse should change the tubing on night shift, weekly. CNA LL stated she checked for the proper storage of respiratory equipment when she enters a resident's room. On 09/17/2020 at 02:34 PM, LN G, stated the resident's individual needs were in the care plan. She reported the respiratory equipment such as tubing and bags are changed out weekly. LN G reported the staff should store the tubing and mask of respiratory equipment in a zip lock bag labeled with initials, and staff should date the bag when changed. On 09/21/20 at 06:43 PM, Administrative Nurse D verified the above observation. She reported staff should change the tubing and bag for storage for respiratory equipment weekly and should store the mask when not in use to prevent infection. The facility policy Infection Management Process, dated 12/2019, documentation lacked address of care and/or storage of respiratory equipment tubing/mask. The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection consistent with standards of practice and person-centered care plan for this resident that required a nebulizer for breathing treatments, related to storage and tubing/mask change of nebulizer kit. - The Medication Review Report, dated 09/04/20, for Resident (R)5, included [DIAGNOSES REDACTED]. The admission Minimum Data Set, (MDS), dated [DATE], assessed R5 as having a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact. She had shortness of breath or trouble breathing with exertion, sitting at rest, and when lying flat. R5 also received oxygen while a resident and while not a resident of the facility. The facility provided respiratory therapy for seven days totaling 285 minutes. The quarterly MDS dated [DATE], assessed R5 with a BIMS score of 15. The resident had no shortness of breath or trouble breathing with exertion, sitting at rest, and when lying flat. She received oxygen. The care plan, dated 06/24/20, indicated R5 had a potential for respiratory distress related to her [DIAGNOSES REDACTED]. The care plan also included that she required oxygen to assist with her breathing. Staff were to change the resident's oxygen tubing and bag weekly, and labeled weekly, on Tuesday evenings, as well as the nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) kit and bag. The Certified Medication Aide (CMA) Medication Administration Record [REDACTED]. This was again repeated on 09/15/20, however, observation on /14/20 at 02:40 PM, revealed R5's oxygen tubing on the portable oxygen bottle lacked a date. On 09/16/20 at 09:43 AM, R5 rested in her bed with her oxygen in place. The oxygen tubing lacked a date. In addition, the resident had a humidifier bottle connected to the concentrator, which also lacked a date. The filter of the concentrator had a build-up of lint/dust. The nebulizer kit was in the plastic bag dated 09/15/20 and stored, assembled, and lacked a date. The facility failed to date the tubing for the oxygen and nebulizer kit and failed to disassemble the nebulizer kit for storage in the plastic bag. On 09/16/20 at 09:52 AM, Administrative Nurse D revealed staff should rinse the nebulizer kits with warm water, set the pieces on a paper towel to air dry inside of a plastic bag. Staff should leave the bag open after the administration of a breathing treatment. Staff should date and change the nebulizer kits weekly. Staff should date the tubing and the plastic bags. In addition, staff should change and date the Oxygen tubing weekly. The humidifier bottles should be dated. The facility Skills Check-Medication Administration (Nebulizer), undated, directed staff to disconnect the nebulizer reservoir and clean (rinse with warm water) after a breathing treatment. The policy lacked instruction on storage of the equipment following cleaning. In addition, the facility policy Infection Management Process, dated 12/2019 lacked direction on storage of oxygen tubing when not in use and labeling and dating tubing as well as for humidifier bottles. The facility failed to ensure adequate sanitation for the resident's nebulizer kit, failed to keep the oxygen concentrator filters cleaned, and failed to date respiratory equipment, which could increase the risk of R5 developing a respiratory infection. - The Medication Review Report, dated 09/09/20, for Resident (R)14, included [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), dated [DATE], assessed R14 as having a Brief Interview of Mental Status (BIMS) score of 15, indicating she was cognitively intact. She had shortness of breath or trouble breathing when sitting at rest and when lying flat. She received oxygen. The annual MDS dated [DATE], assessed R14 as having a BIMS score of 15. She continued to receive oxygen. The care

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) plan, dated 07/22/20, indicated R14 required oxygen at all times to assist with her breathing. She had a potential for respiratory distress related to her [DIAGNOSES REDACTED]. The Medication Review Report, dated 09/09/20, included orders to change the resident's nebulizer and oxygen tubing, every Tuesday. The orders also included for staff to label and date the respiratory tubing. On 09/15/20 at 08:36 AM, R14's nasal cannula lacked a date. In addition, the nebulizer mask had moisture in the mask area and the mask was dirty. The nebulizer kit stored in a plastic container and was assembled. On 09/16/20 at 08:16 AM, R14's nebulize kit remained in a plastic container. The nebulizer kit remained assembled, with moisture in the chamber. The nebulizer tubing lacked a date. In addition, the resident's oxygen tubing lacked a date, and the oxygen concentrator filters had a build-up of lint. On 09/16/20 at 09:23 AM, R14 was in her room receiving her breathing treatment. After the resident completed her breathing treatment, Licensed Nurse (LN) I shut off the nebulizer, removed the nebulizer mask from the resident and placed the unrinsed, unassembled nebulizer a plastic bag. On 09/16/20 at 09:27 AM, LN I reported staff should change the nebulizer kits weekly. LN I verified she failed to separate the nebulizer and cleanse the nebulizer after the resident's breathing treatment. She confirmed the oxygen tubing, the humidifier bottle, and the nebulizer kit lacked a date. LN I also confirmed the filters on the oxygen concentrator had a build-up of lint and required cleaning. On 09/16/20 at 09:52 AM, Administrative Nurse D revealed staff should rinse the nebulizer kits with warm water, and air dry the nebulizer parts on a paper towel inside of a plastic bag. Staff should change the nebulizer kits weekly, and date the tubing. In addition, staff should change the resident's oxygen tubing weekly, and date the tubing. The humidifier bottles should be dated. The facility Skills Check-Medication Administration (Nebulizer), undated, directed staff after completion of the nebulizer treatment, to disconnect the nebulizer reservoir and clean (rinse with warm water). The policy lacked instruction on storage of the equipment following the cleaning. In addition, the facility policy Infection Management Process, dated 12/2019 lacked direction on storage of oxygen tubing when not in use and labeling and dating tubing as well as for humidifier bottles. The facility failed to ensure adequate sanitation for the resident's nebulizer kit according to the facility's nebulizer administration procedure and failed to ensure the oxygen concentrator filters were clean and all tubing dated, which increased the risk of R14 developing a respiratory infection. - The Hospice Comprehensive Assessment and Plan of Care Update Report, dated 08/26/20, for R140, included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE] was in progress. The care plan, dated 09/10/20, included a problem that R140 required the use of oxygen at all times to assist in her breathing, and she had the potential for respiratory distress related to the [DIAGNOSES REDACTED]. Review of the electronic medical record, from dates 09/01/20 through 09/16/20, lacked instruction on when to change the tubing and date it, and when to change the nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) kit and date it. On 09/15/20 at 11:45 AM, R140's tubing lacked a date, the nebulizer kit had moisture present, was connected, and was lying in a plastic container with the nebulizer machine. On 09/16/20 at 09:37 AM, R140's oxygen cannula lacked a date, the humidifier bottle lacked a date, and the oxygen concentrator lacked filters (there was a place for them on each side of the machine). On 09/17/20 at 10:39 AM, R140's nebulizer kit connected, and resting on the holder on the machine, rather than in the bag separated that was on the bedside table, in a plastic container, and dated 09/15/20. On 09/16/20 at 09:52 AM, Administrative Nurse D revealed staff should rinse the nebulizer kits with warm water, set it out to dry on a paper towel inside of a plastic bag, leaving the bag open after administration of a treatment. Staff should change the kits weekly and the tubing should be dated. Staff should change the oxygen tubing weekly, and the tubing should be dated. The humidifier bottles should also be dated. The facility Skills Check-Medication Administration (Nebulizer), undated, directed the staff that when the nebulizer treatment finished, disconnect the nebulizer reservoir and clean (rinse with warm water). The policy lacked instruction on storage of the equipment following cleaning. In addition, the facility policy Infection Management Process, dated 12/2019 lacked direction on storage of oxygen tubing when not in use and labeling and dating tubing as well as for humidifier bottles. The facility failed to ensure adequate sanitation for the resident's nebulizer kit according to the facility's nebulizer administration procedure, failed to ensure the oxygen concentrator had filters in place, and failed to ensure all tubing were dated. - The signed physician orders [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], assessed R10 with a Brief Interview of Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The care plan dated 07/20/2020, instructed staff that R10 required oxygen at all times. Staff should check the resident's oxygen saturations every shift, and as needed. The physician orders [REDACTED].), ordered 11/15/19. 2. Change the resident's 2 oxygen tubing and storage bag, label and date, at bedtime, every Tuesday, ordered 06/23/2020. On 09/14/2020 at 03:52 PM, the resident's nasal cannula had a date of 08/19/20. The filter on the concentrator covered with fuzz and dust. The humidifier lacked a date. On 09/16/2020 at 07:58 AM, R10's oxygen cannula was lying directly on the floor. On 09/16/2020 at 08:18 AM, Certified Nurse Aide (CNA) M, picked the oxygen cannula off the floor and applied R10's oxygen cannula. On 09/16/2020 at 08:21 AM, CNA M confirmed staff should replace the oxygen tubing once the cannula was on the floor. On 09/16/2020 at 08:25 AM, CNA N confirmed staff should replace the oxygen tubing if the cannula touched the floor. On 09/21/2020 at 09:50 AM Licensed Nurse H confirmed R10 used oxygen. Staff should replace the oxygen tubing if the cannula was on the floor. On 09/21/2020 at 10:21 AM Administrative Nurse D explained staff should change the oxygen cannula on Tuesdays. She also confirmed, if an oxygen cannula was on the floor, it needs to be replaced. The facility policy, Infection Management Process, dated 12/2019, lacked a policy for oxygen care. The facility failed to change the oxygen tubing after coming in contact with the floor, failed to date the tubing and humidifier bottle, and failed to clean the oxygen concentrator filter, to prevent possible further respiratory infections for this resident, that required respiratory equipment.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents with 18 selected for review including five residents reviewed for unnecessary medications. Based on record review and interview, the facility failed to act timely upon recommendations of the consultant pharmacist for Resident (R)8 and R5. Findings included: - The Medication Review Report, dated 09/09/20, for Resident (R)8, included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed R8 as having a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact. R8 was continent of bowels and did not have constipation. He was not on a scheduled pain medication, received as needed pain medication, and rarely had pain. R8 received an opioid (class of medications used to reduce pain) one day. The quarterly MDS, dated [DATE], assessed R8 as having a BIMS score of 15, and always incontinent of bowels. R8 was not on a scheduled pain medication, received as needed pain medication, and frequently had pain. He received an opioid medication seven days. The care plan, dated 06/24/20, included that R8 had pain, and to administer pain medications as ordered, administer as needed pain medications as ordered, and monitor effectiveness of the pain medication. Furthermore, the care plan included that R8 had orders for [MEDICATION NAME] (opioid medication for treatment of [REDACTED]. The care plan lacked information on bowel function. The Medication Review Report, dated 09/09/20, revealed R8 had an order, dated 04/01/20, for [MEDICATION NAME] 5 milligrams (mg), every 12 hours as needed for pain. Additionally, the report contained an order, dated 01/20/22 for Senna S twice daily for constipation, an order dated 01/22/20 for [MEDICATION NAME], 100 mg, twice daily for constipation, and an order, dated 02/14/20 for [MEDICATION NAME] powder daily for constipation. Review of the progress notes, dated 07/22/20, revealed the pharmacist recommended to keep the physician informed of frequent [MEDICATION NAME] use, as R8 usually requested the medication about the same time each evening, and Perhaps it could be scheduled for better pain control. Review of the progress notes, dated 08/20/20, revealed the pharmacist recommended notifying the physician of frequent refusals of several doses of medications ([MEDICATION NAME], and Senna) for re-evaluation of R8's condition, Perhaps one or more of the medications could be discontinued. Review of the progress notes dated 07/22/20 through 09/15/20 lacked documentation of physician notification of the pharmacist recommendations. On 09/21/20 at 12:13 PM, Licensed Nurse (LN) H revealed administration Takes care of the pharmacy recommendations. On 09/21/20 at 12:23 PM, Administrative Nurse D revealed she received the pharmacy reviews and sends the information to the physician. Furthermore, she confirmed that the physician was not notified of the of the pharmacist recommendation made in July 2020 and August 2020. The facility policy Medication Regimen Review and Reporting, dated 09/08, directed the resident-specific medication regimen review recommendations and findings are documented and acted upon by the nursing care center and/or physician. The facility failed to follow up on the pharmacist recommendations on two occasions for R8. - The Medication Review Report, dated 09/04/20, for Resident (R)5,

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F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed R5 as having a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact and the resident received an antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication. Her PHQ-9 (an assessment tool used to grade severity of depression symptoms) score was 00, indicating no depression, and she received and antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression) medication seven days. The [MEDICAL CONDITION] Drug Use Care Area Assessment (CAA), dated 03/03/20, revealed that R5 had orders for [MEDICATION NAME] (antianxiety medication) and [MEDICATION NAME] (antianxiety medication) for anxiety. Staff should monitor R5 for adverse behaviors and she was at increased risk for falls related to the medication use. R5 also had orders for [MEDICATION NAME] (an antidepressant) for depression. The quarterly MDS, dated [DATE], assessed R5 as having a BIMS score of 15, PHQ-9 score of 00, and she continued to receive antianxiety and antidepressant medication. The care plan, dated 06/24/20, included that R5 received antianxiety medications for irritability and restlessness, and that the medication had a black box warning (the strongest form of warning required by the Food and Drug Administration that indicates an increased risk of serious adverse reactions associated with the use of a medication). Additionally, the care plan included that R5 received an antidepressant, [MEDICATION NAME]. The Medication Review Report, dated 09/04/20, included an order dated on 03/12/20 for [MEDICATION NAME] 0.5 milligrams (mg), every 24 hours, as needed for anxiety. An additional order, dated 03/12/20, included [MEDICATION NAME] 1 mg, every 12 hours, as needed. R8 also had an order, dated 03/12/20 for [MEDICATION NAME] (an antianxiety medication) 7.5 mg, twice daily for anxiety and [MEDICATION NAME] 20 mg every day for major [MEDICAL CONDITION]. Review of the progress notes, dated 11/12/19, revealed the pharmacy consultant recommended that a stop date required for the as needed [MEDICATION NAME]. The progress notes, dated 01/14/20, revealed the pharmacy consultant recommended to discontinue the as needed [MEDICATION NAME]. The progress notes, dated 02/10/20, revealed the pharmacy consultant recommended discontinuation of as needed [MEDICATION NAME] and a gradual dose reduction of the [MEDICATION NAME]. Review of the electronic medical record and the paper record lacked response from the physician for the pharmacy recommendations on 11/12/19, 01/14/20, and 02/10/20. On 09/21/20 at 12:13 PM, Licensed Nurse (LN) H, revealed that the Administration Nurse reviewed the pharmacy recommendations for any new physician orders. On 09/21/20 at 04:43 PM, Administrative Nurse D reported that she could not locate responses from the pharmacy recommendations for 11/12/19, 01/14/20, and 02/10/20. The facility policy Medication Regimen Review and Reporting, dated 09/08, directed that resident-specific medication regimen review recommendations and findings are documented and acted upon by the nursing care center and/or physician. The facility failed to follow up on the pharmacist recommendations on three occasions for R5.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents with 18 selected for review including five residents reviewed for unnecessary medication monitoring. Based on interview and record review, the facility failed to adequately monitor Resident (R)8's orders for notification to the physician when the resident's blood sugar was out of the ordered parameters. Findings included: - The Medication Review Report, dated 09/09/20, included a [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed Resident (R)8 as having a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact. He received insulin injections seven of the seven days of the assessment period. The quarterly MDS, dated [DATE], assessed R8 as having a Brief Interview of Mental Status (BIMS) score of 15 and received insulin injections seven of the seven days of the assessment period. The care plan, dated 07/16/20, included that R8 had uncontrolled blood sugars, and staff should monitor his blood sugars as ordered and report any unusual fluctuations to his physician. The Medication Review Report, dated 09/09/20, included an order with a start date of 06/22/20 for [MEDICATION NAME] (insulin) flex pen solution, 100 unit/milliliter (ml) per sliding scale, three times a day with meals. The sliding scale order for the resident's blood sugar levels included: 1. If the blood sugar levels were between 100-150, give 3 units. 2. If the blood sugar levels were between 151-200, give 5 units. 3. If the blood sugar levels were between 201-250, give 8 units. 4. If the blood sugar levels were between 251-300, give 12 units. 5. If the blood sugar level were 301 and greater, give 15 units. 6. Notify the resident's physician (PCP) if his blood sugar level was greater than 300 or less than 70. The Licensed Nurse Medication Administration Record [REDACTED]. On 08/13/20 his blood sugar was 312, on 08/14/20 his blood sugar was 315, and on 08/19/20 his blood sugar was 319. Furthermore, the Licensed Nurse MAR, dated 09/01/20 through 09/15/20, revealed R8 had a blood sugar level of 58, which was out of parameters. Review of the progress notes, dated 08/14/20 through 08/19/20, lacked notification to the physician of the blood sugar levels out of parameters on 08/13/20, 08/14/20, and 08/19/20 and 09/15/2020. On 09/21/20 at 12:13 PM, Licensed Nurse (LN) H revealed that when the resident's blood sugar was out of parameters, nurses should document the blood sugars in the progress notes and notify the physician by telephone. Furthermore, she confirmed that the medical record lacked documentation that staff notified the physician when R8's blood sugar levels were out of parameters on 08/13/20, 08/14/20, 08/19/20, and 09/15/20. On 09/21/20 at 12:23 PM, Administrative Nurse D confirmed staff should document out of parameter blood sugars in the nurse's notes. Furthermore, she confirmed that the medical record lacked documentation of physician notification on 08/13/20, 08/14/20, 08/19/20, and 09/15/20. The facility lacked a policy for physician notification when blood sugar levels are out of parameters. The facility failed to adequately monitor Resident (R)8's orders for notification to the physician when the resident's blood sugar was out of the ordered parameters.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents with 18 residents selected for review, including five residents sampled for medication review. Based on record review and interview the facility failed to address physician orders [REDACTED]. Findings included: - The Medication Review Report, dated 09/04/20, for Resident (R)5 included a [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed R5 as having a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact and the resident received an antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) medication. The [MEDICAL CONDITION] Drug Use Care Area Assessment (CAA), dated 03/03/20, revealed that R5 had orders for [MEDICATION NAME] (antianxiety medication) and [MEDICATION NAME] (antianxiety medication) for anxiety. Staff should monitor R5 for adverse behaviors and she was at increased risk for falls related to the medication use. The quarterly MDS, dated [DATE], assessed R5 as having a BIMS score of 15 and she continued to receive an antianxiety medication. The care plan, dated 06/24/20, included that R5 received antianxiety medications for irritability and restlessness, and that the medication had a black box warning (the strongest form of warning required by the Food and Drug Administration that indicates an increased risk of serious adverse reactions associated with the use of a medication). The Medication Review Report, dated 09/04/20, included an order dated on 03/12/20 for [MEDICATION NAME] 0.5 milligrams (mg), every 24 hours, as needed for anxiety. An additional order, dated 03/12/20, included [MEDICATION NAME] 1mg, every 12 hours, as needed. Review of the pharmacy recommendation, signed by the physician on 05/28/20, revealed the physician changed the [MEDICATION NAME] order to one mg, every 12 hours, as needed for anxiety, and may have an additional 0.5mg, every 24 hours, if needed for a severe anxiety episode. The facility failed to adjust the order on the Medication Administration Record [REDACTED]. The Licensed MAR, for dates 07/01/20 through 07/31/20, revealed staff administered [MEDICATION NAME] 0.5 mg, 10 of 14 times prior to administrating [MEDICATION NAME] one mg first. The Licensed MAR, for dates 08/01/20 through 08/31/20, revealed staff administered [MEDICATION NAME] 0.5 mg nine of 16 times prior to administering [MEDICATION NAME] one mg first. The Licensed MAR, for dates 09/01/20 through 09/15/20, revealed staff administered [MEDICATION NAME] 0.5mg four of six times prior to administration of the [MEDICATION NAME] one mg first. On 09/21/20 at 12:13 PM, Licensed Nurse (LN) H, revealed that Administration Nurse reviewed the pharmacy recommendations for any new physician orders. On 09/21/20 at 05:03 PM, Administrative Nurse D reported that R5 liked to Choose her own dose. The facility policy Medication Regimen Review and Reporting, dated 09/08, lacked direction on addressing physician order [REDACTED]. The facility failed to address physician orders [REDACTED].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175464	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES INDEPENDENCE	**1000 MULBERRY, PO BOX 627 INDEPENDENCE, KS 67301**

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

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F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4)
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 41 residents. Based on observation, record review, and interview, the facility failed to count the number of controlled narcotic (a drug affecting mood or behavior) medications stored in the medication cart at each shift change and failed to document on the individual controlled medication sheet when removing a medication from the controlled medication card, which increased the risk of diversion (the transfer of any legally prescribed controlled substance from the individual for whom it was prescribed to another person for any illicit (forbidden by law, rules, or custom)) use. Findings included: - On 09/14/20 at 01:54 PM, review of the shift to shift count sheet for controlled medications lacked documentation of the number of controlled items counted at shift change between two licensed nurses. On 09/14/20 at 01:55 PM, Licensed Nurse (LN) I revealed during shift count the number of pills were counted but not the number of cards. For any controlled medications that required the medication destroyed, two nurses should count the number of pills or amount of liquid medication, sign the individual count sheet, then staff should wrap the sheet around the medication and place in the locked drawer at the bottom of the medication cart. That drawer of the cart is not counted during shift count, it is passed on to Administrative Nurse D, and she would remove the controlled medications out of the bottom of the medication drawer. Staff should notify Administrative Nurse D a narcotic medication needs destroyed. On 09/14/20 at 02:00 PM, observation of the individual controlled sheet compared to the medication card in the cart revealed two residents that the number of pills in the card failed to match the individual controlled medication sheet. Resident (R)5's controlled medication sheet for [MEDICATION NAME] (strong pain medication) 5-325 milligrams revealed one pill left and the medication card was empty, and R15's controlled medication sheet for [MEDICATION NAME] 5-325 milligrams revealed six pills left, and the card revealed five pills left. On 09/15/20 at 02:02 PM, LN I reported she gave the medication to R5 and R15 this morning and charted in the electronic medical record (EMR) but had not signed it out on the individual controlled medication sheet. Furthermore, she reported that when she administers a controlled medication, she would write a note on paper and highlight it when she documented the administration of the medication in the medication administration record (MAR), then would highlight again when she documented on the individual controlled medication sheet. On 09/16/20 at 10:05 AM, Administrative Nurse D, reported that the process for controlled medications instructed staff should document the administered medication in the MAR and on the controlled medication sheet. Nurses should write down the medication, when it was given, how many pills were left, then transfer that information to the individual controlled medication sheet. When controlled medications are discontinued, the Licensed nurse gives the medication to me and I place in a locked box in a locked cabinet until it is able to be destroyed with the pharmacist. Furthermore, nurses should keep the controlled medication that required the medication to be destroyed in the drawer with the other controlled medications, and count the medications until the medication can be given to the Administrative Nurse D. Administrative Nurse D confirmed during shift change, nurses count the number of pills in each card but failed to count the number of controlled cards in the cart. On 09/17/20 at 08:28 AM, Administrative Nurse D confirmed the following medications were stored in the bottom drawer of the medication cart to be destroyed: 1. R7 had a [MEDICATION NAME] bottle that contained 185 milliliters (ml) and another bottle that contained 16.75 ml of medication. 2. R144 had a card of [MEDICATION NAME] 10-325 milligrams (mg), with 44 pills remaining in the card of medication. 3. R30 had a card of [MEDICATION NAME], with 80.5 pills remaining in the card of medications. 4. R33 had a card of [MEDICATION NAME], 5-325 mg with 16 pills remaining in the card of medications. 5. R143 had a card of [MEDICATION NAME], 5-325 mg with 30 pills remaining in the card of medications. 6. R37 had a card of [MEDICATION NAME] 0.5 mg with nine pills remaining in the card of medications. The facility policy Controlled Medication Reconciliation, dated 10/2014, directed staff should reconcile the controlled medications at each shift change or with a change in licensed nurse responsibility for controlled medications. A controlled medication sheet would be utilized to deter diversion. The controlled medication inventory sheet would maintain a log of the total number of cards, bottles, boxes, or vials present on the medication cart or storage area. The licensed nurse would adjust the total number of items on the sheet when a medication received. When the licensed nurse administers the last dose from a card, bottle, box, or vial, the date, medication, resident's name, and items out will be adjusted, and the licensed nurse will sign the entry on the sheet. At each shift change or with a change in licensed nurse responsibility for the medication cart or storage area, the oncoming licensed nurse would count each of the items (cards, bottles, boxes, vial, etc.) and reconcile the total number with the number on the medication inventory sheet. The facility failed to count the number of controlled medications stored in the medication cart at each shift change, and failed to document on the individual controlled medication sheet when removing a medication from the controlled medication card, which increased the risk of diversion.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** The facility reported a census of 41 residents. Based on observation, record review , and interview, the facility failed to maintain a clean and sanitary dietary department, to ensure proper sanitation for the residents of the facility, to prevent food-borne illnesses. Findings included: - During a tour of the dietary department on 09/14/2020 at 01:23 PM, with dietary manager BB revealed the following areas of concern: 1. The wall behind the stove/grill had a build-up of grime. 2. The stove knobs and oven handle had a thick build-up of grime. 3. The sprinklers above the stove contained grime and a build-up of dust. 4. The metal shelves, above the counter, contained crumbs and a build-up of a sticky substance. 5. A kitchen timer had a build-up of a sticky grime. 6. The window above the sink was dusty and had a build-up of cobwebs on the screen. 7. The cabinet doors had areas that lacked paint. 8. The plate warmer had a build-up of food substance on the rear panel. On 09/21/2020 at 02:00 PM, dietary manager BB verified these areas required cleaning. The facility policy, Dietary Services, undated, documented Cleaning schedules are established and posted and must be checked weekly .Effective procedures for the cleaning and maintenance of all equipment and work areas have been developed. The facility failed to maintain a clean and sanitary dietary department, to ensure proper sanitation for the residents of the facility to prevent food-borne illnesses.