STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175286	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHEATLAND NURSING & REHABILITATION CENTER	320 S LINCOLN ST RUSSELL, KS 67665

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 37 residents. The sample included 12 residents with one reviewed for positioning. Based on observation, record review, and interview, the facility failed to ensure appropriate Broda chair (specialized wheelchair with the ability to tilt and recline) positioning in accordance with professional standards of practice for one sampled resident, Resident (R) 31. Findings include: - R31's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had moderately impaired cognition with memory problems, inattention, and verbal behaviors. The MDS recorded R31 required extensive staff assistance with transfers and positioning, impaired balance, unable to walk, and used a wheelchair for mobility. The Activities of Daily Living (ADLs) Care Plan, dated 07/24/20, recorded R31 had a history of [REDACTED]. The care plan directed staff to provide R31 extensive assistance to transfer and position. Review of R31's Electronic Medical Record (EMR) lacked documentation staff assessed the resident for positioning in her Broda chair. On 08/25/20 at 09:54 AM, observation revealed R31 rested quietly in her Broda chair with the chair tilted back and her feet dangled approximately a foot above the floor. On 08/26/20 at 11:47 AM, observation revealed staff propelled R31, seated in her Broda chair, to the dining room. Continued observation revealed R31's feet dangled approximately a foot above the floor. On 08/26/20 at 10:23 AM, Certified Nurse Aide (CNA) M stated staff provided R31 extensive assistance to transfer and position in her Broda chair. On 08/26/20 at 02:14 PM, Licensed Nurse (LN) G stated staff provided R31 extensive assistance to transfer and position in her Broda chair. LN G stated staff repositioned R31 in her Broda chair as needed, the resident's Broda chair had no lower extremity support device, and R31's lower extremities dangled without support. On 08/26/20 at 04:19 PM, Administrative Nurse D stated staff had not assessed R31 for positioning in her Broda chair, the resident's Broda chair had no lower extremity support device, and R31's lower extremities dangled without support. The facility's Repositioning policy, dated May 2013, directed staff to provide appropriate positioning for all chair bound residents to promote circulation, prevent pain and provide comfort. The policy directed staff to provide comfortable support for arms and legs with lack of strength and limited range of motion. The facility failed to ensure appropriate Broda chair positioning in accordance with professional standards of practice for R31, placing the resident at risk for increased pain and restlessness.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 37 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to follow up with the physician when Resident (R) 33 ran out of his [MEDICATION NAME] (a muscle relaxer) medication. Findings included: - On 08/26/20 at 07:42 AM, observation during medication administration revealed Certified Medication Aide (CMA) R went to administer R33's [MEDICATION NAME] medication but found the medication card empty. Observation revealed the medication card read ordered 08/22/20 and awaiting physician approval. The Physician Order, dated 03/03/20, instructed staff to administer [MEDICATION NAME], 10 milligrams (mg), one half tablet, three times a day. Review of the August 1-26, 2020 Medication Administration Record [REDACTED]. (11 missed doses) The Nurse's Note,' dated 08/23/20 at 12:25 PM, documented the resident remained out of [MEDICATION NAME] 10 mg tablets and awaited the refill approval. The Nurse's Note, dated 08/24/20 at 03:54 PM, documented the resident's [MEDICATION NAME] unavailable and the pharmacy awaited the physician's refill approval. The Nurse's Note, dated 08/25/20 at 05:34 PM, documented the resident's [MEDICATION NAME] unavailable and the pharmacy awaited the physician's refill approval. The Nurse's Note, dated 08/26/20 at 07:46 AM, documented the pharmacy had not delivered the resident's [MEDICATION NAME]. On 08/26/20 at 07:42 AM, CMA R verified the resident had been out of his [MEDICATION NAME] since 08/22/20 and the facility had none available to administer. On 08/27/20 at 09:13 AM, CMA S stated she called the pharmacy for a resident's refill on medication when the resident had seven-eight days of a medication left. On 08/26/20 at 08:27 AM, Administrative Nurse D verified the resident's [MEDICATION NAME] was unavailable, stated she called the pharmacy the previous day, and the pharmacy informed her they were waiting for the physician to approve the medication refill. Administrative Nurse D stated staff should call the pharmacy for medication refills when there was five days left in the medication card, it was not good that R33 was still out of his [MEDICATION NAME], the resident took it for muscle spasms in his back, and she would call the physician today. On 08/26/20 at 08:30 AM, Administrative Nurse D stated she called the physician and the physician's office nurse reported the approval for the resident's [MEDICATION NAME] had been sent to the wrong pharmacy. Administrative Nurse D stated the pharmacy delivered medications daily to the facility and they would bring it today. Upon request, the facility failed to provide a policy for pharmacy services. The facility failed to follow up with the physician, when R33 ran out of his [MEDICATION NAME], placing the resident at risk for developing back spasms and pain.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 37 residents. The sampled included 12 residents. Based on observation, record review, and interview, the facility staff failed to properly administer [MEDICATION NAME] (a prefilled device with fast acting insulin) for Resident (R) 33 and Humalog Kwikpen (a disposable single patient prefilled pen containing a fast-acting insulin) for R3. Findings included: - On 08/24/20 at 11:32 AM, observation during medication administration revealed Licensed Nurse (LN) H informed R3 she was going to administer his [MEDICATION NAME] insulin. Observation revealed LN H turned the dose on the resident's [MEDICATION NAME] flex pen to 19 units and administered the medication to the resident without priming (removable of air) with two units prior to administration. On 08/27/20 at 03:00 PM, Administrative Nurse D stated the nurse should prime the resident's [MEDICATION NAME] with two units prior to administration. The undatedPatient Information [MEDICATION NAME] Injection Instructions for Use of [MEDICATION NAME] Instruction Sheet instructed staff to give the air shot before each injection, turn the dose selector to select two units, hold the [MEDICATION NAME] Flex Pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. The sheet instructed staff to keep the needle pointing upwards, press the push button all the way in until the dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. The facility staff failed to prime R3's [MEDICATION NAME] with two units prior to administration, placing the resident at risk for receiving an inadequate insulin dosage. - On 08/26/20 at 04:06 PM, observation during medication administration revealed Administrative Nurse G dialed 10 units of Humalog [MEDICATION NAME]

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 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) (a prefilled device with fast acting insulin) and administered it to R33 without priming the Flex Pen with two units prior to administration. On 08/26/20 at 04:06 PM, Administrative Nurse G verified she had not primed the [MEDICATION NAME] with two units prior to administering the medication and stated she was unaware she was supposed to. The Humalog KwikPen Instruction sheet, dated April 2020, instructed staff to prime the resident's pen by turning the dose knob to select two units. Hold the pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the cop. Continue holding the pen with the needle pointing up. Push the dose knob in until it stops at 0. The facility staff failed to prime R33's Humalog [MEDICATION NAME] with two units prior to administration, placing the resident at risk for receiving an inadequate insulin dosage.
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 had a census of 37 residents. Based on observation, record review, and interview, the facility failed to prepare, store, and serve meals under sanitary conditions for the 35 residents who received meals from the facility kitchen. Findings included: - On 08/24/20 at 09:44 AM, observation during the initial tour of the kitchen revealed the following: One unlabeled (no resident names) box of Ensure (a nutritional supplement) with five individual containers with an expiration date of May 2020. Air intake registers dirty with a gray furry substance. Dead bugs dried to the wall in the south corner and a smooth gray substance on the corner of the south wall. A gray smooth substance on the wall above the freezers. On 08/25/20 at 12:07 PM, observation revealed Maintenance Staff (MS) U entered the kitchen without wearing a hairnet. On 08/26/20 at 01:17 PM, observation revealed Dietary Staff (DS) CC wore a hairnet with 2-3 inches(in) of multiple strands of hair along her neck line and approximately 3 in of pony tail hanging out of her hairnet. On 08/24/20 at 09:44 AM, DS BB stated the Ensure was brought in by family. On 08/25/20 at 12:07 PM, DS BB verified MS U should have worn a hairnet when he entered the kitchen. On 08/26/20 at 01:17 PM, DS BB verified DS CC should have all of her hair in the hairnet, there was dirt on two of the air returns in the kitchen, and stated maintenance cleaned the air returns. On 08/26/20 at 02:42 PM, DS BB verified the wall in the south corner was dirty and she was the one that cleaned the walls. On 08/27/20 at 09:45 AM, MS U verified he cleaned the air returns in the kitchen monthly. The facility's Foods Brought by Family/Visitors policy, dated July 2017, documented that food brought to the facility by visitors/family that is left for the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. Containers will be labeled with the resident's name, the item, and the use by date. The facility's Food Preparation and Service policy, dated July 2014, documented that food service employees shall prepare and serve food in a manner that complies with safe food handling practices. Dietary staff shall wear hair restraints (hair net, hat, beard restraint) so that hair does not contact food. The facilities Sanitation policy, dated October 2008, documented that the food service area shall be maintained in a clean and sanitary manor. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently to prevent accumulation of grime. The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 35 residents who received meals from the facility kitchen, placing the residents at risk for food borne illnesses.