STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175333	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HICKORY POINTE CARE & REHAB	**700 CHEROKEE PO BOX 307 OSKALOOSA, KS 66066**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** The facility had a census of 41 residents. Based on observation, record review, and interview, the facility failed to provide a safe, clean, comfortable environment on four of five facility hallways. Findings included: - On 03/17/2020 at 04:20 PM, observation during the environmental tour with Administrative Staff A and Maintenance Staff (MS) U revealed the following: Front entry way floor tile with a dull finish. North Hall Floor tile with a dull finish. 7 foot (ft) long brown dried substance on floor tile. Hallway ceiling outside of main bath and soiled utility room with 3 ft x 2 ft brown stain and flaking ceiling. North hall resident room floors with a dull finish. South Hall Floor tile with a dull finish. 7 ft long brown dried substance on floor tile Hallway ceiling outside of main bath and soiled utility room with 3 ft x 2 ft brown stain and flaking ceiling. South hall resident room floors with a dull finish. Hallway outside of Great room and dining room floor tile with a dull finish. Great room ceiling above couch with a 2 ft x 3 ft crack and flaking ceiling and 2 ft long brown stain on ceiling above sink. Dining room ceiling above sink with a 3 ft x 3 ft brown stain and cracked flaky substance. Special Care Unit (SCU) floor tile with a dull finish. SCU living room ceiling above the table with 2 ft x 2 ft cracked and flaky brown substance. SCU resident room floors with a dull finish. On 03/17/2020 at 04:30 PM, Administrative Staff A and Maintenance Staff (MS) U verified the environmental findings. Upon request, the facility unable to provide a preventative maintenance policy. The facility failed to provide a safe, clean, comfortable environment for four of five facility hallways, placing the residents in the facility at risk for an uncomfortable environment.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 41 residents. The sample included 12 residents with seven reviewed for accidents. Based on observation, record review, and interview, the facility failed to assess and provide supervision to prevent accident for two of seven sampled residents, Resident (R) 14 lacked a smoking assessment and R11 fell from bed. Findings included: - R14's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS recorded the resident independent for transfers, bed mobility, personal hygiene, dressing, and locomotion on and off the unit. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 05/04/2019, directed staff to allow the resident adequate time to complete her ADLs and encouraged the resident to do as much for herself as possible. The Smoking Care Plan, dated 03/13/2020, directed staff to allow the resident to exit the front door, sign herself out of the building, take a walk, and smoke. The care plan recorded the nurse would provide the resident cigarettes from the medication cart and obtain the cigarettes from the resident when she returned from the walk. The care plan recorded the resident walked independently and verified she would not leave the property if there was inclement weather or before sunrise or after sunset. On 03/16/2020 at 04:00 PM, observation revealed R14 dressed in a heavy winter coat and scarf on her head, signed herself out of the facility. Observation revealed the resident ambulated independently to the porch in front of the facility, smoked a cigarette, then returned to the facility, and signed herself back in. Review of R14's medical records lacked a smoking assessment. On 03/17/2020 at 01:20 PM, Administrative Nurse E verified the facility was a smoke free building but the resident did leave the facility premises if she smoked. Administrative Nurse E verified R14 lacked a smoking assessment and had smoked since her admission to the facility 04/17/19. The facility's Smoke Free policy, dated November 2016, documented the facility is committed to providing a safe and healthy workplace and to promote the health and well-being of its residents and employees and has adopted the following policy which shall apply to all resident, employees, contractors and visitors. The policy documented employees are not allowed to assist residents in smoking as they are not allowed to leave the campus property while working. Resident who violate this smoking policy may be subject to discharge per the facility admission agreement. The facility failed to complete a smoking assessment for R14, who exited the facility's building unattended to smoke a cigarette, placing the resident at risk for accidents and injury. - R11's physician's orders [REDACTED]. The Quarterly MDS, dated [DATE], documented the resident had severe cognitive impairment with inattention and disorganized thinking. The MDS documented the resident required extensive assistance of one to two staff for activities of daily living (ADLs), assistance for balance and transfers, ambulated with a walker or wheelchair, and had no falls. The Fall CAA, dated 10/18/2019, documented the resident required cognitively impaired, required extensive staff assistance with transfers, and at risk for falls. The Fall Care Plan, dated 03/05/2020, documented R11 at risk for falls and trauma related to impulsive behaviors and lack of safety awareness. The care plan directed staff to encourage the resident to ask for assistance, place the call light in the resident's reach, anticipate needs, and report agitation to the nurse. The Nurse's Note, dated 10/22/2019 at 04:20 PM, recorded staff found the resident on the floor with a 1.0 centimeter (cm) abrasion. The note lacked documentation of the location of the resident or the location of the fall. On 03/16/2020 at 01:00 PM, observation revealed the resident propelled her wheelchair from the dining room to her room. On 03/17/2020 at 02:00 PM, Administrative Staff A verified the resident fell and the fall had not been reported or investigated. Administrative Staff A verified she was the Director of Nursing at that time, did not receive information or a report R11 fell on that date. Administrative staff contacted the previous Administrator, but he was unable to locate any information on the fall. Administrative Staff A verified she called the Certified Nurse Aide (CNA) working the date and time of the residents fall, the CNA stated the resident was located between the bed and the wall and the abrasion was on the resident's right knee. No other information was reported or recorder. The facility's Fall Assessment and Prevention policy, dated July 2017, documented a comprehensive fall assessment will be conducted on admission. If and when a resident has a fall, root cause analysis will be conducted to assist in planning appropriate evidence-based interventions to prevent further falls. After a fall the facility would ensure that the resident needs are met, ant the resident is safe. Make them comfortable, attend to any immediate medical needs and provide appropriate interventions. Assess the scene and begin the fall scene investigation report, a root cause analysis tool for falls that looks at internal, environmental and operational/systemic conditions that may have contributed to be responsible for the fall. The policy documented the facility would notify the physician, DPOA and complete the resident incident report and investigation. Document the fall in the nursing chart tab, complete a fall assessment, and discuss the new interventions that were immediately implemented. Update the resident care plan in ECS with the appropriate interventions to keep the resident safe until reviewed by the interdisciplinary team the following business day. The facility failed to investigate, report, and prevent R11 from falling, placing the resident at risk for further falls and injury.

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1)
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 had a census of 41 resident. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility's pharmacy consultant failed to identify Resident (R) 16's inappropriate [DIAGNOSES REDACTED]. Findings included: - R16's Physician order [REDACTED]. The Significant Change Minimum Data Set (MDS), dated [DATE], recorded the resident had moderately impaired cognition and received antipsychotic medication daily. The Significant Change Care Plan, dated 01/16/2020, directed staff to monitor the resident for behaviors. The care plan documented the resident received scheduled [MEDICATION NAME] for agitation with a Black Box Warning (BBW-strictest warning placed in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug): [MEDICATION NAME] not approved for agitation and can increase mortality (death) risk and adverse side effects in elderly dementia residents. The [MEDICAL CONDITION] Medication Care Area Assessment CAA), dated 01/16/2020, recorded the resident received [MEDICATION NAME] at bedtime for agitation. The Physician Order, dated 01/12/2020, directed staff to administer [MEDICATION NAME] 5 mg by mouth (PO) at bedtime. The Pharmacist Reviews, dated 01/23/2020 and 02/18/2020, failed to address the resident received [MEDICATION NAME] with an inappropriate diagnosis. On 03/16/2020 at 09:30 AM, observation revealed the resident lying on his bed on his right side. On 03/17/2020 at 02:10 PM, Administrative Nurse E verified R16 routinely received [MEDICATION NAME] at bedtime for the [DIAGNOSES REDACTED]. The facility's pharmacy consultant failed to alert the facility of R16's inappropriate [DIAGNOSES REDACTED].
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 had a census of 41 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure one of five sampled residents had a 14 day stop date on as needed (PRN) [MEDICATION NAME] (antianxiety medication-that calms and relaxes people with excessive restlessness, nervousness and tension), Resident (R) 14, and failed to ensure two of five sampled residents, R16 and R18 had an inappropriate [DIAGNOSES REDACTED]. Findings included: - R14's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS recorded the resident independent with transfers, bed mobility, personal hygiene, dressing, and locomotion on and off the unit. The MDS recorded the resident received antipsychotic medication seven days in the lookback period. The [MEDICAL CONDITION] Drug Use Care Area Assessment (CAA), dated 05/04/2019, documented the resident received an antipsychotic medication one or more of the last seven days. The CAA directed staff to monitor the resident for side effects every shift and notify the physician of any symptoms and unusual behaviors. The Behavioral Care Plan, dated 03/13/2020, recorded the resident had verbally abusive behaviors, mood changes, anxiety, agitation and depression. The care plan directed staff to offer the resident reassurance, encourage decision making, assist with activities, and allow ventilation of feelings. The care plan lacked documentation of the residents PRN use of [MEDICATION NAME] for anxiety. The physician's orders [REDACTED]. R14's medical record lacked a 14 day stop date for the PRN [MEDICATION NAME]. On 03/16/2020 at 04:00 PM, observation revealed R14 signed herself out of the facility and ambulated independently to the porch in front of the facility, smoked a cigarette, then returned to the facility, and signed herself back in. On 03/17/2020 at 01:10 PM, Administrative Nurse E verified the resident had frequent behaviors related to agitation towards other residents, visitors, and staff, and became confrontational, bossy, and difficult to redirect at times. Administrative Nurse E verified the PRN [MEDICATION NAME] lacked a 14 day stop date. The facility's Antipsychotic Medication policy, dated April 2014, recorded the medications would be prescribed at the lowest possible dose for the shortest period and are subject to gradual dose reduction and review. The policy recorded the residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The policy documented if antipsychotic medications are administered as PRN dosages over days, the physician would evaluate the resident to determine if his/her symptoms were responding to the medication. The consultant pharmacist would ensure use of [MEDICAL CONDITION] medication comply with federal regulations. The facility failed to ensure R14's PRN [MEDICATION NAME] had a 14 day stop date, placing the resident at risk for adverse medication side effects. - R18's POS, dated 3/02/2020 recorded a [DIAGNOSES REDACTED]. The Significant Change MDS, dated [DATE] recorded the resident had severely impaired cognitive skills. The MDS recorded the resident required staff supervision with walking in room and corridor, totally dependent on staff with personal hygiene, toilet use, eating and dressing, and received an antipsychotic medication (medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions). The Behavioral Care Plan, dated 01/11/2020, directed staff to monitor the resident for behaviors, wandering, intruding on the privacy of others, and elopement. The care plan directed staff to administer antipsychotic medications as ordered and monitor/document for side effects and effectiveness. The Physician Order, dated 03/02/2020 (original order 10/02/19), directed staff to administer [MEDICATION NAME] (antipsychotic) 0.25 mg by mouth (PO) twice daily for Alzheimer's. The Food and Drug Administration (FDA) documents [MEDICATION NAME] has the following Black Box warning (BBW-strictest warning placed in the labeling of prescription drugs or drug products by the FDA when there is reasonable evidence of an association of a serious hazard with the drug): [MEDICATION NAME] is not approved for depression or dementia due to the medication is not effective for the treatment of [REDACTED]. On 03/16/2020 at 03:30 PM, observation revealed the resident walked around in the dining room, walked over to another resident seated in a wheelchair, rubbed her back, then continued to walk up and down the halls. On 03/17/2020 at 01:10 PM, Administrative Nurse E verified the [DIAGNOSES REDACTED]. The facility's Antipsychotic Medication policy, dated April 2014, recorded the medications would be prescribed at the lowest possible dose for the shortest period and are subject to gradual dose reduction and review. The policy recorded the residents would only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The policy documented if antipsychotic medications are administered as PRN dosages over days, the physician would evaluate the resident to determine if his/her symptoms were responding to the medication. The consultant pharmacist would ensure use of [MEDICAL CONDITION] medication comply with federal regulations. The facility's failed to ensure an appropriate [DIAGNOSES REDACTED]. - R16's POS, dated 01/31/2020, recorded [DIAGNOSES REDACTED]. The Significant Change MDS, dated [DATE], recorded the resident had moderately impaired cognition and received an antipsychotic medication daily. The Significant Change Care Plan, dated 01/16/2020 , directed staff to monitor the resident for behaviors. The care plan documented the resident received scheduled [MEDICATION NAME] for agitation with a BBW: [MEDICATION NAME] is not approved for agitation, and can increase mortality (death) risk and adverse side effects in elderly dementia residents. The [MEDICAL CONDITION] Medication CAA, dated 01/16/2020, recorded the resident received [MEDICATION NAME] at bedtime for agitation. The Physician Order, dated 01/12/2020, directed staff to administer [MEDICATION NAME] 5 mg PO at bedtime. The Pharmacist Reviews, dated 01/23/2020 and 02/18/2020, failed to address the resident received [MEDICATION NAME] with an inappropriate diagnosis. On 03/16/2020 at 09:30 AM, observation revealed the resident lying on his bed on his right side. On 03/17/2020 at 02:10 PM, Administrative Nurse E verified R16 routinely received [MEDICATION NAME] at bedtime for agitation. On 03/17/2020 at 02:30 PM, Administrative Nurse D verified the resident received [MEDICATION NAME] for the [DIAGNOSES REDACTED]. The facility failed to ensure an appropriate [DIAGNOSES REDACTED].

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.**

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) The facility had a census of 41 residents. The sample included two residents. Based on observation, record review and interview, the facility failed to prepare, store, distribute, and serve food under sanitary conditions for the 40 residents who received meals from the facility kitchen. Findings included: - On 03/12/2020 at 08:10 AM, observation during initial kitchen tour revealed the following: One - 4 foot (ft) overhead florescent light fixture inside the South hallway entrance door, with two bulbs covered with gray hanging lint. Four - 4 ft overhead florescent light fixtures, one located in front of the refrigerator, one over the three-compartment sink, one located over the food preparation area, and one located behind the stove, covered with gray hanging. The food preparation sink located on the North wall, an area approximately 2 ft x 10 inches (in) extending from the ceiling to the cabinet top with plaster and paint chips lifted from the wall. The ceiling in the Northwest corner of the food preparation area with a brown water stain approximately 12 in x 10 in of textured ceiling paint flake off and covered with a register grill. The ceiling in the North east corner directly above the three-compartment dishwashing sink with a brown water stain approximately 2 ft x 18 in with textured ceiling paint flaked off the area. A 12 in x 12 in brown metal register vent located outside the dry storage room, covered with gray hanging lint, blowing directly on the food preparation area. On 03/12/2020 at 08:40 AM, Dietary Staff (DS) BB verified the kitchen had lint on the overhead florescent light fixtures, water spots with the textured ceiling and paint flaked off the area, and a metal register grill with hanging gray lint. Upon request, the facility unable to provide a cleaning and preventative maintenance policy. The facility failed to prepare, store, distribute and serve food under sanitary conditions for the 40 residents who received meals from the facility kitchen.
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** The facility had a census of 41 residents. Based on observation, record review, and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment in the facility kitchen. Findings included: - On 03/12/2020 at 08:30 AM, observation during the initial kitchen tour revealed the food preparation area with 8 inch (in) x 8 in discolored square tiles, dingy with multiple brown rust stains, and missing chips of tile. Continued observation revealed an approximately 2-foot (ft) x 2 ft area of missing floor tiles under the three compartments sink. On 03/12/2020 at 08:45 AM, observation in the steam room located directly across from the main kitchen revealed multiple discolored and dingy 8 in x 8 in square tiles with multiple brown rust stains and chips of tile missing. Continued observation revealed an approximately 2 ft x 3 ft area of missing floor tiles under the dishwasher area. Continued observation revealed the baseboard and kitchen floor with brownish debris/grime between the tile and along the baseboard. On 03/12/2020 08:40 AM, Dietary Staff (DS) BB verified the dull and dingy kitchen floor with missing tiles, and the brown grease and grime build up on the floor. Upon request, the facility unable to provide a preventative maintenance and repair schedule for the flooring in the kitchen and steam room. The facility failed to provide a provide a safe, functional, sanitary, and comfortable environment in the facility kitchen.