STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E580	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER LODGE	**300 W 3RD, PO BOX 487 COLDWATER, KS 67029**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census was 26 with 12 residents included in the sample. Based on observation, interview, and record review the facility failed to verify Resident (R) 23's Advance Directives (a legal document in which a person specifies what actions should be taken for their health), the staff failed to know the code status, and the facility provided conflicting information regarding the residents code status to the staff responsible for R23's care. Findings included: - Review of the Physician order [REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00 indicating Severe cognitive impairment. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment. Review of R23's current Care Plan revealed the resident was a DNR (Do Not Resuscitate) in the informational section at the top of each page along with the residents name. The body of the Care Plan did not address advance directives. Review of the medical chart revealed the residents Face Sheet under the section titled Additional Information listed R23's code status as DNR. Review of R23's medical chart revealed it did not contain a Do-Not-Resuscitate form. Review of the physician's orders [REDACTED]. An observation on [DATE] at 08:56 AM revealed R23 with no sticker on the name plaque near his door, but R23's chart at the nurse's station had a red heart sticker. During an interview on [DATE] at 09:34 AM, Certified Nurse Aid (CNA) E stated she knew the stickers represented the residents wish to be a DNR or a full code (CPR performed). CNA E stated she did not know which sticker meant DNR or full code. During an interview on [DATE] at 09:59 AM, Certified Medication Aid (CMA) I stated she could not remember what the stickers on the resident name plaques meant. CMA I stated the facility kept a key at the nurse's station for the meaning of the stickers. An observation on [DATE] at 10:02 AM revealed the key for the stickers meaning located at the nurses' station. The key revealed a red heart indicated the resident's full code status, and a yellow star indicated the resident's DNR code status. During an interview on [DATE] at10:14 AM Licensed Nurse (LN) J stated a red heart sticker meant the resident was a full code, and a yellow star meant the resident was a DNR. LN J stated these stickers were placed on the residents' doors, and on the medical chart at the nurses' station. LN J stated she knew of the discrepancy concerning R23's code status. The face sheet showed the resident was a DNR, but the chart did not contain a DNR. The sticker on the chart was a red heart which meant R23 was a full code. During an interview on [DATE] at 10:16 AM Administrative Nurse B stated R23's chart had a red heart, and the physician order [REDACTED]. Administrative Nurse B stated she expected the staff to initiate CPR in the case of an emergency. Administrative Nurse B stated on admission the social service director discussed code status with the residents and their family. Review of the facility's policy titled Advance Directives dated ,[DATE] stated, .Every resident will be asked on admission if the resident has executed an advance directive .The resident's advance directive will be reviewed on admission, with any significant change in condition and at least quarterly during the care plan conference to ensure full understanding and continued wishes of the resident/representative . The facility failed to verify the code status, the staff did not know of the resident's code status, and the facility provided conflicting information to staff regarding code status for R23's care.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 26 residents with 12 included in the sample. Based on observation, record review, and interview, the facility failed to revise the care plan for Resident (R) 11 related to the use of oxygen. Findings included: - Review of Physician order [REDACTED].) Review of the Annual Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10 indicating mildly impaired cognition.R11 experienced shortness of breath or trouble breathing with exertion. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 11 indicating moderately impaired cognition. R11 experienced shortness of breath or trouble breathing with exertion. Review of the Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/01/19 revealed R11 had [DIAGNOSES REDACTED]. Review of the Physician order [REDACTED]. An observation on 03/11/20 at 08:03 AM revealed R11's oxygen tubing, and bubbler with no date indicating the last time staff changed them, and no plastic bag in which to store the oxygen tubing and nasal cannula when not in use. During an interview on 03/11/20 at 09:08 AM, Certified Nurse Aide (CNA) F stated R11 needed the use of oxygen when in bed. During an interview on 03/11/20 at 09:13 AM, Licensed Nurse (LN) G stated R11 required the use of oxygen mostly when she laid down in bed but did not use it when she came out for meals. During an interview on 03/11/20 at 11:08 AM, Administrative Nurse H stated anyone could add things to the care plan, but stated she mostly updated the care plan. Administrative Nurse H stated she thought the use of oxygen should be included in R11's care plan. Review of the Care Plan Revisions policy revised 11/2019 revealed, The care planning process includes .revision of care and treatment in order to meet the patient's needs .When changes in condition, medications, treatments or approaches occur, the plan of care will be updated immediately by hand and written on the plan of care. The facility failed to revise the care plan to include information related to the use of oxygen for R11.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 26 residents with 12 included in the sample with one resident reviewed for the use of oxygen. Based on observation, record review, and interview, the facility failed to provide necessary respiratory care and/or services consistent with professional standards of practice when they failed to change, and date disposable oxygen equipment for Resident (R) 11. Findings included: - Review of Physician order [REDACTED].) Review of the Annual Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating mildly impaired cognition. R11 experienced shortness of breath or trouble breathing with exertion. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating moderately impaired cognition. R11 experienced shortness of breath or trouble breathing with exertion. Review of the Cognitive Loss/Dementia Care Area Assessment (CAA) dated 07/01/19 revealed R11 with the [DIAGNOSES REDACTED]. Review of the Physician order [REDACTED]. Review of the January 2020 Medication Record revealed O2 cannula and nebulizer set up every month on the 15th lacked documentation of completion. Review of the February 2020 Medication Record revealed O2 cannula and nebulizer set up every month on the 15th lacked documentation of completion. An observation on 03/11/20 at 08:03 AM revealed R11's oxygen tubing and bubbler were not dated to indicate the last time

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) they were changed, and no plastic bag observed in which to store the oxygen tubing and nasal cannula when not in use. During an interview on 03/11/20 at 09:08 AM, Certified Nurse Aide (CNA) F stated R11 needed the use of oxygen when in bed. CNA F stated the night shift staff were responsible for changing the oxygen tubing, but CNA F did not know how often they did this. CNA F stated it was his understanding the oxygen tubing were to be labeled with the date staff changed it. During an interview on 03/11/20 at 09:13 AM, Licensed Nurse (LN) G stated R11 required the use of oxygen mostly when she laid down in bed but did not use it when she came out for meals. LN G stated she thought the oxygen tubing should be replaced weekly by night shift. LN G stated the oxygen tubing should be labeled with the date staff replaced it. During an interview on 03/11/20 at 01:22 PM, Administrative Nurse stated the oxygen tubing should be changed monthly and expected the tubing to be dated. Review of the Administration of Oxygen policy dated 05/2019 revealed, Store all cannulas, oxygen tubing and nebulizer masks in plastic bag when not in use .Oxygen tubing will not be draped across bedroom furniture or equipment .Disposable cannulas, nebulizer masks and tubing will be changed monthly on the night shift and plastic storage bag will be changed and dated monthly on the night shift . The facility failed to change and date disposable oxygen equipment for R11.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**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 26 residents. Based on observation and interview the facility failed to serve food in accordance with professional standards for food service safety, ensuring the residents remain free from infections, when observations revealed dietary staff did not hold, deliver, and transport resident food/cups in a sanitary manner Findings included: - On 03/09/20 at 11:35 AM Dietary Staff (DS) D observed passing out beverages and touched the tops/lips of glasses multiple times. On 03/09/20 at 11:59 AM Certified Nurse Aide (CNA) E observed handing a resident a cup of juice while holding on to the top of the cup. On 03/09/20 at 12:06 PM DS D observed delivering a resident their food using a tray. DS D placed the food items on the table appropriately but moved the glasses and cups out of the way by holding the tops of the glasses and cups for two residents, then DS D brought a large glass of tea and held the top of the glass. On 03/09/20 at 12:10 PM DS D observed cutting a baked potato for a resident and used his ungloved fingers to keep the potato from moving while he used a fork to cut up the potato. On 03/10/20 at 08:50 AM DS D stated he should hold cups by the base and not touch the tops. During an interview on 03/11/20 at 10:16 AM, Certified Dietary Manager (CDM) C stated she expected all of her staff to know how to move a glass or cup on the table and to know the correct way to carry them. CDM C stated she did the education for the dietary staff on their tasks. Review of the Safe Food Preparation and Handling Practices policy revised 01/13/2016 revealed, Utensils and drinkware shall be handled in such a way as to avoid touching any surface that food or drink will come in contact with. The facility failed to distribute and serve food in accordance with professional standards for food service safety to prevent the outbreak of foodborne illness when observations revealed dietary staff did not hold, deliver, and transport resident food/cups in a sanitary manner.