STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175077	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF OSAWATOMIE	**1615 PARKER AVENUE OSAWATOMIE, KS 66064**

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 0561 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents, with 18 residents sampled, including three residents reviewed for room changes. Based on interview and record review, the facility failed to follow up on room changes on three of the three Residents (R)#17, R 29, R 45 sampled for room changes. Findings included: - The Physician order [REDACTED].#17 had a [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. He required total assistance of two staff for transfers and extensive assistance of two staff for bed mobility and dressing. He had impairment on both sides of his lower extremities. The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 06/28/19, documented the resident required assistance of two staff for transfers and used an electric wheelchair for mobility. The ADL Care Plan, dated 01/15/20, instructed staff to turn and reposition the resident every two hours and as needed (PRN). The resident's medical record from 07/01/19 to 03/09/20, documented the resident moved to a different room twice: 12/01/19 and 12/09/19. The medical record lacked documentation of follow up with the resident from facility staff as to his well-being following the room changes. On 03/03/20 at 10:20 AM, the resident stated staff moved him to different rooms several times. He stated they had not followed up with him to see if he was doing alright in the new rooms. On 03/04/20 at 03:19 PM, Activity staff Z stated she would follow up with residents the next day following room changes. On 03/09/20 at 09:56 AM, Administrative Nurse D stated stated there was no follow up following the resident room changes. The facility policy for Resident Room Relocation, effective 05/06/19, included: The Social Services staff will make a follow-up visit, as needed, after the move to aid in adjusting to the new room. The facility failed to follow up with this resident following a room change. - The Physician order [REDACTED].#29 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. He required extensive assistance of two staff for bed mobility, transfers, and toilet use. The ADL (Activities of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 10/27/19, documented the resident required assistance with ADLs due to weakness and [MEDICAL CONDITION]. The ADL Care Plan, dated 02/27/20, instructed staff the resident was non-weight bearing and had a trapeze (a short horizontal bar hung by ropes or metal straps from a support, to help with mobility) for bed mobility. The resident's medical record from 02/01/20 to 03/09/20, documented the resident moved to a different room on 02/14/20. The medical record lacked documentation of follow up with the resident from facility staff as to his well-being following the room change. On 03/03/20 at 08:11 AM, the resident stated he was not happy with the room change and staff had not followed up with him regarding how he was doing with a roommate. On 03/04/20 at 03:19 PM, Activity staff Z stated, she would follow up with residents the next day following room changes. On 03/09/20 at 09:56 AM, Administrative Nurse D stated, stated there was no follow up following the resident room changes. The facility policy for Resident Room Relocation, effective 05/06/19, included: The Social Services staff will make a follow-up visit, as needed, after the move to aid in adjusting to the new room. The facility failed to follow up with this resident following a room change. - The Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating he had intact cognition. He required extensive assistance of two staff for bed mobility, transfers, dressing, and toilet use. The ADL (Activities of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 11/19/19, documented the resident required staff assistance with ADLs. The ADL Care Plan, dated 02/25/2020, instructed staff the resident had left sided weakness. The resident's medical record, from 11/12/19 to 03/09/20, documented the resident moved three times: 01/13/20, 02/14/20, and 03/02/20. The medical record lacked documentation of follow up with the resident from facility staff as to his well-being following the room changes. On 03/04/20 at 09:30 AM, the resident stated he was not happy with the latest room. He stated he moved many times and had problems settling in to new rooms. On 03/04/20 at 03:19 PM, Activity staff Z stated, she would follow up with residents the next day following room changes. On 03/09/20 at 09:56 AM, Administrative Nurse D stated, stated there was no follow up following the resident room changes. The facility policy for Resident Room Relocation, effective 05/06/19, included: The Social Services staff will make a follow-up visit, as needed, after the move to aid in adjusting to the new room. The facility failed to follow up with this resident following a room change.
F 0576 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents have reasonable access to and privacy in their use of communication methods.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 55 residents which included 5 residents reviewed for privacy. Based on record review and interview, the facility failed to ensure packages addressed to 2 residents Resident (R) 16 and R13, of the 5 residents reviewed for privacy were delivered to residents unopened. Findings included: - Review of R16's Physician order [REDACTED]. The Quarterly Minimum Data Set ((MDS) dated [DATE], assessed the resident with normal cognitive status and no impairment in upper extremities. The Annual MDS, dated [DATE], assessed the resident with normal cognitive status and no impairment in upper extremities. The ADL (Activities of Daily Living)/Functional Rehabilitation Care Area Assessment (CAA), dated 06/26/19 assessed the resident required supervision of ADLs. The Care Plan, reviewed 12/27/19, instructed staff the resident required assistance with ADLs. Interview on 03/02/20 at 03:46 PM with the resident revealed staff opened his packages delivered from the mail order supplier of a specialized medication that staff administered to him. The resident saved the box and it revealed the shipping label contained his name, and c/o (care of) A Hall, and the facility address. Interview on 03/05/20 at 10:30 AM with the resident revealed Licensed Nurse (LN) HH opened a package delivered to the facility, addressed to him on this day. Interview on 03/05/20 at 11:30 AM with LN HH revealed she ordered the medication directly from the mail order supplier. LN HH stated the resident does not self-administer medications and she feared the resident would not notify staff that he had received the shipment of medications, causing missed doses. LN HH stated she did open the box containing the medication as the shipping label indicated c/o A Hall and she thought this was the proper procedure. Interview on 03/05/20 at 1:30 PM with Administrative Staff A revealed staff did open the packages of medications from the mail order pharmacy to ensure uninterrupted administration of the medication. Administrative Staff A expressed fear that the resident received package of the medication, but would not inform staff possibly causing missed doses. Administrative Staff A stated she would devise a plan where staff would take the unopened package of medications for the mail order pharmacy to the resident, allow him to open it, then give the medication to the staff member. Interview on

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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LIFE CARE CENTER OF OSAWATOMIE	1615 PARKER AVENUE OSAWATOMIE, KS 66064

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F 0576 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 03/05/20 at 1:50 PM with the resident revealed he declined to speak to the administrator, but would speak to the ombudsman or surveyor. Interview on 03/09/20 at 2:15 PM with the resident and Resident Advocate GG, (with resident consent) revealed the resident was in agreement with facility staff bringing the mail order medication package to him to open, then giving the medication to staff for administration. The facility policy Resident Rights, dated 04/15/19, instructed staff the resident had the right to send and receive mail and to receive letters, packages, and other materials delivered to the facility promptly and unopened. The facility failed to ensure this resident received his packages unopened. - Review of Resident (R)13's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], assessed the resident with moderate cognitive impairment, required extensive assistance of two staff for activities of daily living, and no impairment of upper extremities. The ADL (Activities of Daily Living)/Functional Rehabilitation Care Area Assessment (CAA), dated 03/14/19 did not trigger. The Care Plan reviewed 01/15/20, instructed staff the resident had an ADL performance deficit. Interview on 03/03/04/20 at 1:06 PM with the resident revealed dietary staff CC, (formerly housekeeping/maintenance) opened two of her packages before bringing them to her. The resident stated this happened several months ago, but did not inform the administrator. Interview on 03/04/20 at 1:30 PM with Licensed Nurse (LN) K revealed when a package came in staff should deliver it directly to the resident. Interview on 03/09/20 at 2:30 PM with Administrative Staff A revealed the resident did not inform the facility that the former housekeeping/maintenance/dietary Staff CC opened two of her packages. Administrative Staff A stated staff should not open a resident's packages or mail without the resident's permission. The facility policy Resident Rights, dated 04/15/19, instructed staff the resident had the right to send and receive mail and to receive letters, packages, and other materials delivered to the facility promptly and unopened. The facility failed to ensure this dependent resident received her packages unopened.
F 0583 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 18 residents sampled, including five residents reviewed for privacy. Based on observation, interview, and record review, the facility failed to provide personal privacy for four of the five, Residents (R) 17, R13, R29, and R38, while staff provided personal cares in their rooms. Findings included: - The Physician order [REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. He required total assistance of one staff for toileting and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 06/28/19, documented the resident was dependent on staff for catheter care. The Urinary Incontinence care plan, dated 01/15/2020, instructed staff the resident had an indwelling urinary catheter due to urine retention. On 03/03/2020 at 10:20 AM, the resident stated the staff come in and out of his room when he was only partially or totally uncovered and he did not like that. He felt he was visible to anybody in the hallway at those time. On 03/04/2020 at 01:53 PM, Certified Nurse Aide (CNA) Q was giving cares to the resident. CNA Q walked out of the resident's room, without pulling the privacy curtain, while he was only partially covered with a sheet. His bare abdomen and legs were visible to anybody in the hallway. On 03/05/2020 at 05:19 AM, CNA M entered the resident's room without awaiting an answer to the knock. The resident was partially uncovered, with nothing covering his bottom half. On 03/04/2020 at 01:53 PM, CNA Q stated, she did not think about pulling the privacy curtain when she left the resident's room. On 03/05/2020 at 04:59 AM, CNA M stated, she should have waited for the resident to respond to her after knocking on his room door, before entering his room. On 03/09/2020 at 10:58 AM, Administrative Nurse D stated, she would expect staff to ensure resident's are covered and not exposed to anybody in the hallway when they go into or out of the resident room. The facility policy for, Resident Rights, reviewed 04/15/19, included: The resident has a right to be treated with respect and dignity. The facility failed to provide this dependent resident with personal privacy while staff entered and exited his room. - The Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. He required extensive assistance of two staff for bed mobility, transfers and toilet use. The ADL (Activities of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 10/27/19, documented the resident required assistance with ADLs due to weakness and [MEDICAL CONDITION]. The ADL care plan, dated 02/27/2020, instructed staff the resident was non-weight bearing and had a trapeze (a short horizontal bar hung by ropes or metal straps from a support, to help with mobility) for bed mobility. On 03/03/2020 at 08:11 AM, the resident stated staff do not give him privacy. He would have to ask the staff to pull the privacy curtain when they were giving him cares. On 03/03/2020 at 08:11 AM, R29's roommate, R10 stated, he had seen his roommate naked on several occasions. On 03/05/2020 at 04:59 AM, Certified Nurse Aide (CNA) stated, she does not always pull the privacy curtain while giving cares because the roommate was usually asleep. On 03/04/2020 at 09:56 AM, CNA P stated, she did not always pull the privacy curtain while doing cares with the resident. On 03/09/2020 at 10:58 AM, Administrative Nurse D stated, she would expect staff to ensure resident's are covered and not exposed to anybody in the hallway when they go into or out of the resident room. The facility policy for, Resident Rights, reviewed 04/15/19, included: The resident has a right to be treated with respect and dignity. The facility failed to provide this dependent resident with personal privacy while staff entered and exited his room. - Review of R38's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status score (BIMS) of 06 which indicated severe cognitive impairment, and required extensive assistance of two staff for transfers. The Annual MDS, dated [DATE], assessed the resident with a BIMS score of 06. The resident required extensive assistance of 2 staff for transfers, had an unsteady balance, and no falls since prior assessment. The ADL (Activities of Daily Living)/Functional Rehabilitation ADL Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 11/06/19, triggered due to the resident's need for staff assistance. This CAA identified contributing factors of weakness, dementia (progressive mental disorder characterized by failing memory and confusion), and [MEDICAL CONDITION]. The Care Plan, with review date of 02/25/20, revealed the resident had an ADL self-care performance deficit related to dementia. Observation on 03/18/20 at 03:18 PM revealed Certified Nurse Aide (CNA) NN and CNA OO provided perineal care to the resident. The room lacked a privacy curtain that could be drawn to provide privacy for the resident from the opened door to prevent visualization from the hallway and to prevent her roommate from entering the room during resident care. The resident's roommate R 19 (unsampled) opened the door to the room once, and thereafter knocked on the door to the room twice, requesting admission to use the bathroom. CNA NN stated at that time that she did not know why there was not a privacy curtain in this room. Interview on 03/09/20 at 04:00 PM with housekeeping staff V revealed staff launder the privacy curtains, but immediately put one back up so a room should not lack a privacy curtain. Interview on 03/09/20 at 4:12 PM with Administrative Staff A revealed privacy curtains should be in all rooms that house two residents and staff training included their use during orientation. The facility policy Keeping a Resident's Room in Order, effective 08/09/2019, instructed staff that privacy will be provided for each resident with the use of clean cubicle curtains. The facility failed to maintain this dependent resident's privacy with lack of a privacy curtain which also affected the resident's roommate with restricted movement in the room during resident cares. - Review of R13's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], assessed the resident with moderate cognitive impairment, required extensive assistance of two staff for activities of daily living, and no impairment of upper extremities. The ADL (Activities of Daily Living)/Functional Rehabilitation Care Area Assessment (CAA), dated 03/14/19 did not trigger. The Care Plan reviewed 01/15/20, instructed staff the resident had an ADL performance deficit. Observation on 03/03/20 at 11:00 AM revealed the resident positioned in bed, with Consulting Wound Care Staff HH and Licensed Nurse I at the resident's bedside providing wound care without the privacy curtain pulled. Interview on 03/03/20 at 2:45 PM with the resident revealed Certified Nurse Aide staff often enter the shower room while she showered, in addition to the CNA assigned to bathing. The resident stated it bothered her to have these staff members come into the room for supplies while she bathed. Interview on 03/04/20 a 10:54 AM with CNA O revealed staff should not enter the shower room while a resident received a bath. CNA O stated the door had a lock on it and an Occupied sign. The facility policy Resident Rights, reviewed 04/15/19, instructed staff the resident has the right to personal privacy. The facility failed ensure personal privacy for this dependent resident during resident cares.
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.** **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.**

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F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) The facility reported a census of 50 residents. Based on observation and interview, the facility failed to provide necessary housekeeping and maintenance services to maintain an orderly, sanitary and comfortable environment, in resident rooms on two of the three halls, for the residents who reside in these areas of the facility. Findings included: - Environmental tour, on 03/02/2020 at 03:00 PM, revealed the following areas/items of concern: Hall A 1.) An overflowing trashcan, room trays from breakfast and lunch sitting on the sink counter in one resident's room. Hall B 1.) Grimy discolored build-up in the corners and around the perimeter of the floors in eight resident rooms. 2.) Three of eight rooms with cracked floor tiles. 3.) Six of eight resident bathrooms with grime and stains around the base of the toilets. 4.) Three of eight resident bathrooms with stained floor tiles. 5.) Missing trim along the bathroom floor, stains on the wall behind the toilet, and a faint odor of urine in one resident's room. 6.) Missing paint on the bathroom doorframe, a dirty trashcan with no liner, an uncovered bedpan directly on the floor behind the toilet, and multiple black scuff marks on the doors in one resident's room. 7.) Base trim along the floor pulling away from the wall under the sink and in a corner under the window in one resident's room. 8.) Missing paint on a door frame and tiles separating from the wall in the shower in one resident's room. 9.) Black scuff marks on the floor in front of a recliner, missing paint on door frames, and brown drip stains on the wall behind the bathroom sink in one resident's room. Interview, on 03/09/2020 at 03:26 PM, with Certified Nurse Aide (CNA) S, reported meal trays are picked up after meals by the CNA on the floor and placed in the food cart. If the cart was already gone, then the trays are taken back to the kitchen. Interview, on 03/05/2020 at 12:09 PM, with maintenance staff U, verified the above findings and stated those areas need to be addressed. The facility policy for, Housekeeping Services, dated 08/29/2019, documented, . to promote a sanitary environment.3. Clean and disinfect all horizontal surfaces daily, as needed when spills or soiling occurs, and after resident discharge. Examples.floors.5. Clean and disinfect low-touch surfaces on a routine basis and as needed. Examples.walls.Trash will be removed from all areas on a specific schedule to prevent spillage and odors . The facility failed to provide necessary maintenance and housekeeping services to maintain an orderly, sanitary and comfortable environment, in these resident rooms on the A and B halls, for the residents that reside there.
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 reported a census of 55 residents with 18 selected for review. Based on observation, interview, and record review, the facility failed to review and revise the plan of care to ensure staff safely transferred one Resident (R)38 with extensive assist of two staff. Findings included: - Review of R38's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status score (BIMS) of 06 which indicated severe cognitive impairment, and required extensive assistance of two staff for transfers. The Annual Minimum Data Set MDS, dated [DATE], assessed the resident with a BIMS score of 06. The resident required extensive assistance of 2 staff for transfers, had an unsteady balance, and no falls since prior assessment. The ADL (Activities of Daily Living)/Functional Rehabilitation ADL Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 11/06/19, triggered due to the resident's need for staff assistance. This CAA identified contributing factors of weakness, dementia (progressive mental disorder characterized by failing memory and confusion), and [MEDICAL CONDITION]. The Fall CAA, dated 11/06/19, assessed the resident had balance problems, at risk for falls due to dementia, weakness, and incontinence (inability to control bowel and bladder function), and had no falls with injury in the past 90 days. The Care Plan, with review date of 02/25/2020, revealed the following dates for interventions for assistance with transfers: 07/18/19 Required extensive assistance by one staff to move between surfaces as necessary. 01/03/20 required extensive assistance of 2 staff to move between surfaces as necessary. 02/28/20 Required extensive assistance of two staff to move between surfaces as necessary and use the lift for transfers as needed or two person transfer. An addition to the Care Plan, with update 01/13/20, instructed staff to apply the back brace when out of bed. A Nurse Progress Note, dated 12/20/19, revealed Certified Nurse Aide (CNA) PP transferred the resident to her wheelchair, the wheelchair moved backwards during the transfer, and staff lowered the resident to the floor. The brakes were locked on the wheelchair. An X-ray Result Report, dated 01/02/20, revealed osteopenia (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and compression fracture (when forced together bone surfaces caused a bone to break) of L5 (lumbar vertebra in spine) and T12 ([MEDICATION NAME] vertebra in spine), [MEDICAL CONDITION] (worn) changes and age indeterminate compression fractures. Interview and observation on 03/04/20 at 03:18 PM with CNA NN and CNA OO revealed the resident required the sit to stand lift for transfers. CNA NN and CNA OO transferred the resident with the sit to stand mechanical lift at that time. The resident transferred without bearing weight on her legs. The resident had a back brace on. Observation on 03/05/20 at 12:25 PM revealed CNA Q and CNA R transferred the resident with a mechanical lift with a sling from her wheelchair to bed without incident. CNA Q stated the resident at times could transfer with two staff assisting in the past. Interview on 03/09/20 at 8:30 am with Licensed Nurse (LN) J revealed staff now used a lift to transfer the resident since she fell . Interview on 03/09/20 at 10:30 AM, with Administrative Nurse D revealed she investigated the fall and found the CNA PP should have had 2 staff assist with transfers. Administrative Nurse D stated CNA P should follow the care plan, but confirmed staff updated the care plan after the fall. Interview on 03/09/20 at 12:40 PM with Administrative Nurse F confirmed the resident's Annual MDS, dated [DATE], indicated the resident required extensive assistance of two staff for transfers. Review of the electronic medical record Task for transfers, during the seven day look back period, revealed the resident required two staff for four of the seven transfers. Administrative Nurse F stated the previous Quarterly MDS, dated [DATE], also assessed the resident required extensive assistance of two staff. Administrative Nurse F confirmed staff did not update the care plan to transfer the resident with extensive assistance of two staff. The facility policy Resident Assessment Instrument and Care Plan, reviewed 04/29/19, instructed staff the care plan provided a path toward the resident achieving or maintaining their highest practicable level of well-being. The facility failed to review and revise the plan of care to ensure staff transferred this dependent resident in a safe manner to prevent injury.
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 reported a census of 55 residents with 18 selected for review which included 3 residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure staff safely transferred 2 (Resident (R)38 and R28) of the 3 residents reviewed for falls. Findings included: - Review of R38's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status score (BIMS) of 06 which indicated severe cognitive impairment and required extensive assistance of two staff for transfers. The Annual MDS, dated [DATE], assessed the resident with a BIMS score of 06. The resident required extensive assistance of 2 staff for transfers, had an unsteady balance, and no falls since prior assessment. The ADL (Activities of Daily Living)/Functional Rehabilitation ADL Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 11/06/19, triggered due to the resident's need for staff assistance. This CAA identified contributing factors of weakness, dementia (progressive mental disorder characterized by failing memory and confusion) and [MEDICAL CONDITION]. The Fall CAA, dated 11/06/19, assessed the resident had balance problems, at risk for falls due to dementia, weakness, and incontinence (inability to control bowel and bladder function) and had no falls with injury in the past 90 days. The Care Plan, with review date of 02/25/20, revealed the following dates for interventions for assistance with transfers: 07/18/19 Required extensive assistance by one staff to move between surfaces as necessary. 01/03/20 required extensive assistance of 2 staff to move between surfaces as necessary. 02/28/20 Required extensive assistance of two staff to move between surfaces as necessary and use the lift for transfers as needed or two person transfer. An addition to the Care Plan, with update on 01/13/20, instructed staff to apply the back brace when out of bed. A Nurse Progress Note, dated 12/20/19, revealed Certified Nurse Aide (CNA) PP transferred the resident to her wheelchair, the wheelchair moved backwards during the transfer, and staff lowered the resident to the floor. The brakes were locked on the wheelchair. An X-ray Result Report,

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) dated 01/02/20, revealed osteopenia (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and compression fracture (when forced together bone surfaces caused a bone to break) of L5 (lumbar vertebra in spine) and T12 ([MEDICATION NAME] vertebra in spine), [MEDICAL CONDITION] (worn) changes and age indeterminate compression fractures. A physician's orders [REDACTED]. Interview and observation on 03/04/20 at 03:18 PM with CNA NN and CNA OO revealed the resident required the sit to stand lift for transfers. CNA NN and CNA OO transferred the resident with the sit to stand mechanical lift at that time. The resident transferred without bearing weight on her legs. The resident had a back brace on. Observation on 03/05/20 at 12:25 PM revealed CNA Q and CNA R transferred the resident with a mechanical lift with a sling from her wheelchair to bed without incident. Observation on 03/09/20 at 8:30 am revealed the resident seated in her wheelchair in the lobby without her brace on. The resident denied pain. Interview on 03/09/20 at 8:30 am with Licensed Nurse (LN) J revealed staff did not confirm the order for the brace after discharge from acute care and upon return to the facility on [DATE]. LN J did not know if the resident should wear the brace. Interview on 03/09/20 at 8:45 am with a family member revealed the resident had a Magnetic Resonance Image (MRI an in-depth scan of the spine), on 03/06/20, and the physician would decide to discontinue the brace based on the results. Interview on 03/09/20 at 10:30 AM with Administrative Nurse D revealed she investigated the fall and found the CNA PP should have had 2 staff assist with transfers. Administrative Nurse D stated CNA P should follow the care plan, but confirmed staff updated the care plan after the fall. Interview on 03/09/20 at 12:40 PM with Administrative Nurse F confirmed the resident's Annual MDS, dated [DATE], indicated the resident required extensive assistance of two staff for transfers. Review of the electronic medical record Task for transfers, during the seven day look back period, revealed the resident required two staff for four of the seven transfers. Administrative Nurse F stated the previous Quarterly MDS, dated [DATE], also assessed the resident required extensive assistance of 2 staff. Administrative Nurse F confirmed staff did not update the care plan. The facility policy Event Management System Policy, undated, instructed staff to provide supervision and assistive devises to each resident to prevent avoidable accidents. The facility failed to ensure staff transferred this dependent resident in a safe manner to prevent injury. - Review of R 28's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS dated [DATE], assessed the resident, Brief Interview for Mental Status score (BIMS) of 11 which indicated moderate cognitive impairment (8-12) and was independent with transfers and toileting. The Annual MDS, dated [DATE], assessed the resident with a BIMS score of 08 and the resident required limited assistance of 1 person for transfers and toileting. The ADL (Activities of Daily Living)/Functional Rehabilitation Care Area Assessment (CAA), dated 01/24/20, assessed the resident required assistance of one staff with dressing, toileting, had a right arm fracture, used a walker for mobility, and a wheelchair at times. The resident had a fall on 11/25/19 resulting in a right shoulder fracture and wore an immobilizer. The Cognitive Loss CAA, dated 01/24/20, revealed the resident had poor safety awareness. The Falls CAA, dated 01/24/20, revealed the resident had decreased mobility due to right arm fracture and required assistance of one staff for transfers. The resident used a walker for mobility and had several falls in past month feeling dizzy and lightheaded at times. The Care Plan, reviewed 01/17/20, instructed staff the resident had decreased mobility related to weakness and required supervision with activities of daily living. An update to the care plan, dated 01/29/2020 instructed staff the resident required stand by assistance with dressing, transfers, toileting, and will call staff for assistance. An update to the Care Plan, dated 02/20/20, instructed staff to encourage the resident to call staff for assistance. A Nurses' Note, dated 02/13/20 at 04:30 PM, revealed CNA MM propelled the resident seated in her four wheeled walker with seat, backwards in the hallway as the resident felt dizzy. The resident leaned back, the walker collapsed, and the resident fell backwards onto the floor, hitting her shoulders and head. The resident denied pain. Observation on 03/05/20 at 05:56 AM revealed the resident turned on her call light and proceeded to self-transfer from her bed to wheelchair and took herself to the bathroom. Certified Nurse Aide (CNA) RR arrived and assisted the resident from the toilet back to her bed. Interview, at that time with CNA RR, revealed the resident required stand by assistance of one staff for transfers. Interview on 03/05/20 at 11:43 AM, with CNA MM, revealed on 02/13/20, the resident indicated that she was dizzy. CNA MM sat the resident in her walker and propelled the resident backward down the hallway toward her room. CNA MM stated the resident leaned backward in a faint-like posture and the walker collapsed, causing the resident to fall backwards and hit her head and shoulders on the floor. CNA MM stated the resident insisted she use the walker and not a wheelchair. Interview on 03/09/20, 09:30 AM with Licensed Nurse J revealed staff should not propel a resident in a four wheeled walker when in a sitting position. Interview on 03/09/20 at 10:30 AM with Administrative Nurse D revealed she expected staff to obtain a wheelchair for a resident that was dizzy and not transport a resident in a seated position on a 4 wheeled walker with a seat. Administrative Nurse D stated the resident did not sustain an injury and had an evaluation in the emergency room . The facility's Event Management System Policy, undated, instructed staff to provide supervision and assistive devises to each resident to prevent avoidable accidents. The facility failed to propel this resident in a safe manner to prevent injury.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 18 residents sampled, including three residents reviewed for urinary incontinence (involuntary passage of urine) and Indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). Based on interview, record review, and observation, the facility failed to care for the catheter in a clean manner to prevent infections for two of the Residents (R) 17 and R38 sampled. Findings included: - The Physician order [REDACTED]. The Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. He had an indwelling urinary catheter and required total assistance of one staff for toilet use. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 06/28/19, documented the resident was dependent on staff for catheter care. The Urinary Incontinence Care Plan, dated 01/15/20, instructed staff to keep the catheter tubing and bag below the level of the bladder at all times. On 03/04/20 at 12:47 PM, the resident returned from [MEDICAL TREATMENT] pushed in a wheelchair by the transportation company staff. The catheter tubing drug on the floor of the hallway as he went to his room. On 03/04/20 at 01:04 PM, the resident sat up in his wheelchair eating lunch. The catheter tubing remained on the floor beneath his wheelchair. On 03/04/20 at 01:04 PM, Licensed Nurse K stated, the resident's catheter tubing should never drag on the floor. On 03/09/20 at 10:58 AM, Administrative Nurse D stated, catheter tubing should always be kept off of the floor. The facility policy for Urinary Incontinence and Indwelling Urinary Catheter Management, effective 12/11/18, included: Residents are to receive treatment and care in accordance with professional standards of practice. The facility failed to care for the urinary catheter in a clean manner to prevent infections for this dependent resident with a urinary catheter and a recent UTI (Urinary Tract Infection). - Review of R38's Physician order [REDACTED].) The Quarterly MDS (Minimum Data Set), dated 08/06/19, assessed the resident with a Brief Interview for Mental Status score (BIMS) of 06 which indicated severe cognitive impairment, required extensive assistance of two staff for transfers, and frequently incontinent of urine. The Annual MDS, dated [DATE], assessed the resident with a BIMS score of 06. The resident required extensive assistance of 2 staff for transfers, had an unsteady balance and no falls since prior assessment, and was frequently incontinent of urine. The ADL (Activities of Daily Living)/Functional Rehabilitation ADL Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 11/06/19, triggered due to the resident's need for staff assistance. This CAA identified contributing factors of weakness, dementia (progressive mental disorder characterized by failing memory and confusion) and [MEDICAL CONDITION]. The Fall CAA, dated 11/06/19, assessed the resident had balance problems, at risk for falls due to dementia, weakness, and incontinence (inability to control bowel and bladder function). Urinary Incontinence and indwelling catheter CAA, triggered due to need for assistance with ADLs, frequently incontinent of urine, and urinary tract infections. The Care Plan, revised 02/25/20, instructed staff the resident had a urinary catheter due to [MEDICAL CONDITION] bladder and provide catheter care every shift. Observation 03/04/20 at 03:18 PM with CNA NN and CNA OO revealed the resident required the sit to stand lift for transfers. CNA NN and CNA OO transferred the resident with the sit to stand mechanical lift and placed the catheter bag on the floor at that time, then attached the catheter bag to the lift. Once the resident layed in bed, staff attached the bag to a strap hanging from the resident's mattress then lowered the resident's bed. The bottom portion of the catheter bag layed directly on the floor. Interview at that time with CNA OO revealed the catheter bag should not meet the floor and CNA

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	175077	A. BUILDING _____ B. WING _____	03/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF OSAWATOMIE	1615 PARKER AVENUE OSAWATOMIE, KS 66064

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) OO repositioned the catheter so it did not touch the floor. Interview on 03/09/20 at 8:30 am with Licensed Nurse (LN) J revealed staff should not place the catheter bag directly on the floor. Interview on 03/09/20 at 10:30 AM with Administrative Nurse D revealed staff should keep the catheter bag and tubing off the floor. The facility policy for Urinary Incontinence and Indwelling Urinary Catheter Management, effective 12/11/18, included: Residents are to receive treatment and care in accordance with professional standards of practice. The facility failed to ensure sanitary catheter care for this dependent resident with frequent urinary tract infections.
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 reported a census of 50 residents with 18 residents sampled. The sample included one resident reviewed for respiratory. Based on interview, record review, and observation, the facility failed to ensure convenient placement of the oxygen concentrator for one sampled Resident (R) 29. Findings included: - The Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. He required extensive assistance of two staff for bed mobility and transfers, and had limited range of motion (ROM) on both sides of his lower extremities. The ADL (Activity of Daily Living) Care Are Assessment (CAA), dated 10/27/19, documented the resident was at risk for falls and pain due to the [DIAGNOSES REDACTED]. He required extensive assistance of two staff for transfers, extensive assistance of one staff for bed mobility and transfers, and had limited range of motion (ROM) on both sides of his lower extremities. The Respiratory Care Plan, dated 02/27/20, instructed staff the resident used oxygen as needed (PRN) per nasal cannula. The resident's medical record documented a physician's orders [REDACTED]. On 03/03/20 at 08:11 AM, the resident's oxygen concentrator was in the corner of his room, blocked by his bed. On 03/03/20 at 09:29 AM, Certified Nurse Aide (CNA) O provided cares to the resident in his room. CNA O was unable to reach the oxygen concentrator. On 03/04/20 at 09:56 AM, CNA P sat the resident far up in bed and then climbed across the bed frame in order to reach the oxygen concentrator. On 03/03/20 at 08:11 AM, the resident stated staff were unable to reach his oxygen concentrator. In order for staff to reach the concentrator, they needed to climb over him or climb behind his bed. On 03/03/20 at 09:29 AM, CNA O stated, when the resident needed his oxygen, she would crawl behind the head of the bed to get the oxygen tubing and turn the machine on. On 03/04/20 at 09:56 AM, CNA P stated, she can only reach the resident's oxygen tubing and concentrator by going behind the resident's bed. On 03/09/20 at 08:44 AM, Administrative Nurse D stated, the oxygen concentrator should be put in a place where staff can reach it easily. The resident does use the oxygen often. The facility policy for, Keeping a Resident's Room in Order, effective 08/09/19, included: The facility must provide a safe, clean, and comfortable environment which includes ensuring the resident can receive care and services safely and the physical layout of their room maximizes resident independence and does not pose a safety risk. The facility failed to ensure convenient placement of the oxygen concentrator for this dependent resident who received oxygen.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Observe each nurse aide's job performance and give regular training.** The facility reported a census of 50 residents. Based on observation, interview, and record review, the facility failed to ensure four of the five direct care staff reviewed, received twelve hours of continuing education training, to ensure competency in provided care for the residents. Findings included: - During review of five direct care staff's education transcripts, revealed four direct care staff failed to have twelve hours of the required training. On 03/03/20 at 11:50 AM, Administrative Nurse E explained, the facility was lacking in training hours. Administrative Nurse E understood that the staff require twelve hours of required training yearly to ensure competency. The facility policy for, In-service Education and Orientation, dated 6/17/19, documented Certified Nurse Aide training must be sufficient to ensure continuing competence and be no less than twelve hours per year. The facility failed to ensure that all direct care staff received twelve required training hours per year, to ensure competency in care for the residents.
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 50 residents. Based on observation, record review, and interview the facility failed to ensure proper labeling of two insulin pens to ensure the safe storage and administration of the medication and failed to ensure accurate accounting for the non-narcotic medications to be destroyed or returned to the pharmacy. Findings included: - On [DATE] at 3:47 PM, 1.) Initial inspection of the B hall treatment cart with Licensed Nurse (LN) J revealed: A [MEDICATION NAME]pen for Resident (R)198, without instructions on the pen for administration. A [MEDICATION NAME] pen for R198 without instruction for administration. 2.) Initial inspection of the D hall medication storage room with LN J, on [DATE] at 4:03 PM, revealed: 91 pharmacy medication cards of various discontinued and medications to be returned to the pharmacy without a written log for accounting of these medications. On [DATE] at 4:03 PM, LN J, stated the facility places the discharged medications and medications that needed to go back to the pharmacy on the counter. On [DATE] at 12:45 PM, Administrative staff D, stated the facility lacked a system to account for the non-narcotic medications such as these. The facility policy for, Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, dated [DATE], documented the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other applicable law. The facility failed to ensure proper labeling, to ensure safe storage and administration of 2 insulin pens and failed to ensure proper accounting for the disposal of discontinued or discharged medications.
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 50 residents. Based on observation, record review, and interview, the facility failed to store, prepare, and serve food under sanitary conditions from the kitchen to the residents of the facility. Findings included: - During a tour of the dietary department on 03/02/2020 at 03:04 PM, revealed the following. Three nonstick skillets with flaking scratched surfaces, and five cutting boards with deep cuts covering the cutting boards. On 03/04/2020 at 09:50 AM, Dietary staff BB confirmed the three skillets and the cutting boards were in need of replacing. On 03/03/2020 at 12:05 PM, during initial inspection of the activity room refrigerator revealed the following. 1.) Seven opened bottles of undated flavored coffee creamer. 2.) Several opened bottles of undated cocktail sauce. 3.) Two large glass bowls, with unknown substances, and without a date on the bowls. 4.) A refrigerator and freezer with food particles throughout and an unknown hairy type substance on the seal of the freezer. 5.) A half bottle of tea with no name or date on the bottle. On 03/04/2020 at 09:50 AM, Dietary staff BB explained the food in the refrigerator should be dated and the refrigerator lacked a cleaning schedule. The facility, Food Safety Policy, dated 11/28/17, documented Food is stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth. The facility failed to store, prepare, distribute, and serve food under sanitary conditions in the kitchen arecas, for the residents of the facility.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents, with 18 sampled. Based on observation, interview and record review, the facility failed to use proper hand-washing and glove use in an isolation room for one sampled Resident (R) 17, while providing cares. Findings included: - The Physician order [REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating he had intact cognition. He required total assistance of one staff for toileting and had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag). The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 06/28/19, documented the resident was dependent on staff for catheter care. The Urinary

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	175077	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF OSAWATOMIE	**1615 PARKER AVENUE OSAWATOMIE, KS 66064**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) Incontinence Care Plan, dated 01/15/2020, instructed staff the resident had an indwelling urinary catheter due to urine retention. The resident was in isolation due to an infection in his urine, [MEDICATION NAME]-resistant [MEDICATION NAME] (VRE). A physician's orders [REDACTED]. On 03/04/2020 at 01:53 PM, Certified Nurse Aide (CNA) Q and N, donned personal protective equipment (PPE) and gave catheter care to the resident. When finished with the cares, CNA Q put the trash into the red trash can, used in isolation rooms, for disposal. CNA Q then pushed the trash down inside of the trash can using her gloved hand. After pushing the trash down into the trash can, she then picked up the resident's nasal cannula to place it on him. Intervention at this time and the CNA was asked to stop and obtain new tubing and to change her PPE. On 03/04/2020 at 01:53 PM, CNA Q stated, she knew better than to push the trash down in an isolation room trash can, but the trash can was full. On 03/04/2020 at 01:53 PM, CNA N stated, staff should not touch the inside of the isolation trash cans. On 03/09/2020 at 10:58 AM, Administrative Nurse D stated, staff should not put their gloved hands into an isolation trash can to push down the trash. The facility policy for, Personal Protective Equipment, reviewed 07/25/19, included: Staff will change gloves and perform hand hygiene when moving from a contaminated site to a clean site during resident cares. The facility failed to use proper hand-washing and glove use in an isolation room for this dependent resident with current infection.