STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175544	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
IGNITE MEDICAL RESORT A PTR OF THE UNIV OF KANSAS	**3910 RAINBOW BLVD, SUITE 400 KANSAS CITY, KS 66103**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 89 residents. The sample included seven residents. Based on interviews and record reviews the facility failed to provide change of condition notification to Resident (R)2's representative when he transferred to the hospital. Findings included: - R2's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Admission Minimum (MDS) data set [DATE] documented a Brief Interview for Mental Status score of nine, which indicated moderately impaired cognition. He required supervision to total staff assistance with his Activities of Daily Living (ADLs). The Feeding Tube Care Area assessment dated [DATE] documented R2 required a gastrostomy tube ([DEVICE]- surgical creation of an artificial opening into the stomach thru the abdominal wall) due to his [DIAGNOSES REDACTED]. R2's Care Plan dated 06/16/20 documented the staff provided [DEVICE] care as ordered by the physician and monitored for signs of infection. A Progress Note dated 07/18/20 at 07:52 AM documented R2 had pulled his [DEVICE] out. A Progress Note dated 07/18/20 at 09:42 AM documented R2 was transferred to the hospital for replacement of the [DEVICE]. A Progress Note dated 07/19/20 at 06:49 AM documented R2 had pulled out his [DEVICE] out. A Progress Note dated 07/19/20 at 08:43 PM documented R2 had been transferred to the hospital, during the prior shift, for replacement of his [DEVICE]. The Progress Notes lacked documentation for the notification, to R2's legal representative, of the hospital transfers. On 09/15/20 at 09:18 AM R2's spouse stated the hospital staff notified her of the last transfer. The facility notified her the day after the transfer. On 09/15/20 at 03:44 PM Licensed Nurse H stated the residents' legal representatives were always notified of a transfer to the hospital and notification was documented in the residents' EMRs. On 09/15/20 at 05:58 PM Administrative Nurse D stated the residents' legal representatives were always notified of a transfer to the hospital and notification was documented in the residents' EMRs. The facility's Change in Resident Condition policy dated November 2018 documented the facility staff notified the responsible party when a resident was sent to the hospital. The facility failed to notify R2's representative of transfer to the hospital, this had the potential for the inability for the representative to be involved in R2's care and treatment.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 89 residents. The sample included seven residents. Based on interviews, observations, and record reviews the facility failed to provide a safe living environment for Resident (R) 4; when the call light was not placed within her reach. Findings included: - R4's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] documented R4 had a Brief Interview for Mental Status score of 11, which indicated moderately impaired cognition. She required extensive staff assistance with bed mobility, locomotion, dressing, and hygiene. R4 required total staff assistance for transfers, toileting, and personal hygiene. She had no falls since the last MDS entry. The Falls Care Area assessment dated [DATE] documented R4 had the potential for falls and injuries due to impaired mobility, possible medication side effects, and cognitive loss. She required support with transfers. The nursing staff provided safety cues and monitored. A high-low bed and call light at bedside were provided. The Comprehensive Care Plan last revised 07/20/20 documented R4's call light was placed within her reach and she was encouraged to use it for assistance as needed. Prompt response to all requests for assistance was provided. A Progress Note dated 07/23/20 documented R4 was found on the floor at approximately 02:30 AM. She stated she had fallen out of bed when she rolled over. She sustained swelling to the right side of her face and complained of headache. She was transferred to the hospital for further evaluation. 0 09/15/20 at 09:00 AM R4 rested in her bed, on her left side, with the covers pulled up to her neck. The bed was in a high position. A floor mat was on the floor beside the bed. A breakfast tray was on the bedside table, next to the bed. The call light was hanging on the floor. On 09/15/20 at 09:50 AM a staff member entered R4's and exited the room at 09:53 AM. On 09/15/20 at 10:05 AM R4 rested in bed, which was in the high position. She denied pain and stated she felt comfortable in her current position. The call light was hanging on the floor. On 09/15/20 at 10:42 AM a staff member entered the room and exited at 10:48 AM. On 09/15/20 at 10:49 AM R4 had been repositioned in her bed. The bed was in a low position. The call light was hanging on the floor. On 09/15/20 at 12:18 PM a staff member assisted R4 with cares. Repositioned R4 and placed the call light within R4's reach and instructed her in the use. On 09/15/20 at 02:28 PM Licensed Nurse G stated R4 had been sent to the hospital for a fall in the past. She was able to use a call light. On 09/15/20 at 02:49 PM Certified Nurse Aide M stated R4 was at risk for falls and was able to use her call light. She checked for call light placement when she did her resident rounds. On 09/15/20 at 05:58 PM Administrative Nurse D interventions for the prevention of falls were placed in the residents' care plans. The administrative staff did spot checks to ensure interventions were followed. The Fall Prevention Program policy dated November 2018 documented residents' care plans were developed and instituted when they were identified as a high fall risk. The plan of care included interventions to reduce falls and injuries related to falls. The facility failed to ensure a safe environment for R4, when her call light was not placed within her reach. This had the potential for further falls, unnecessary injuries and/or hospitalization s.
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 identified a census of 89. The sample included seven residents. Based on record review and interviews, the facility failed to provide necessary wound care as ordered by the physician for Resident (R) 1. This failure placed R1 at risk for comlpications related to his wound including delayed healing and potential for infection. Findings included: - R1's electronic medical record (EMR) documented he admitted to the facility on [DATE] and discharged on [DATE]. The [DIAGNOSES REDACTED]. The Care Plan dated 07/10/20 documented R1 had actual impairment to skin integrity related to surgical flap repair (healthy, live tissue is surgically removed from one location of the body to another area that has lost skin, fat, muscle, or skeletal support) and directed staff to provide treatments per physician's orders [REDACTED]. for wound care. The order directed staff to cleanse the wound with wound cleanser, pat dry, apply [MEDICATION NAME] (prevents infection of minor cuts, burns, and scrapes when applied topically) , xeroform (sterile non-adhering fine mesh gauze), ABD (highly absorbent dressing that provides padding and protection for large wounds), and secure with [MEDICATION

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) NAME] tape (self-adhesive, non-woven fabric sheet for secure and rapid fixation). An identical wound order with a start date of 07/13/20 and discontinued date of 07/13/20 was ordered as needed. The Treatment Administration Report revealed R1 received wound care one time out of five scheduled times and one time as needed between 07/13/20 to 07/16/20. A Medical Professional Progress Note in the Progress Notes tab of R1's EMR on 07/15/20 at 12:40 PM documented the wound was intact with maceration (softening and breaking down of skin as a result from prolonged exposure to moisture, such as sweat, urine, or feces or wound drainage for extended periods) at the intersection point. The note documented wound care was ordered for twice daily, but not signed off on Medication Administration Record [REDACTED]. A Discharge/Transfer Summary note in the Progress Notes tab of R1's EMR on 07/16/20 at 06:00 PM documented R1 transferred to hospital via emergency medical services at that time. A Medical Professional Progress Note in the Progress Notes tab of R1's EMR on 07/16/20 at 09:50 PM documented the wound had approximated (pulled together) edges, purulent (producing or containing plus) drainage near the junction with surrounding redness. It further recorded R1 wanted to go to the hospital because he had concerns with the care he received in the facility and believed he needed further intervention. On 09/15/20 at 03:44 PM, Licensed Nurse (LN) H stated the charge nurse completed dressing changes unless the wound care nurse was there to do it. She stated one of the reasons a dressing change did not get completed was due to lack of time, but they are not allowed to chart that so there was no documentation as to why it was not done. On 09/15/20 at 03:57 PM, Administrative Nurse D stated dressing changes should have been completed and if the nurse was out of supplies then the nurse should have called the Assistant Director of Nursing or the Director of Nursing to get the supplies. She stated if a resident refused a dressing change it should have been documented. The Wound Care Formulary policy dated November 2018 stateddue to the volume of dressings available and prescribed, each product was to be applied and changed according to physician's orders [REDACTED]. This failure placed R1 at risk for delayed wound healing and complications.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 89 residents. The sample included seven residents reviewed for medications. Based on record review and interviews the facility failed to prevent a significant medication error when they failed to provide the timely administration of intravenous (IV) antibiotic (medications given through the veins to treat infections) for one Resident (R)1. Findings included: - R1's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The EMR under the Minimum Data Set tab documented R1 entered the facility on 07/10/20 and discharged on [DATE] The Care Plan dated 07/10/20 documented R1 received antibiotic medications as ordered by the physician. The staff monitored and documented for side effects and effectiveness of the medication. The Orders tab of the EMR documented an order for [REDACTED]. The MAR indicated [REDACTED]. 07/14/20 the noon dose was given at 02:23 PM and the 06:00 PM dose was given at 07:00 PM, which was only 4 hours in between doses. 07/15/20 the noon dose was given at 03:06 PM and the 06:00 PM dose was given at 05:32 PM, which was only 2 hours in between doses. 07/16/20 the noon dose was given at 02:26 PM A Medical Professional Progress Note dated 07/16/20 documented R1 had requested to be seen by the physician since he did not believe he received his medications as scheduled. R1 requested to be sent to the hospital for further evaluation and interventions. A Social Service Note dated 07/17/20 documented R1 admitted to the hospital on [DATE]. On 09/15/20 at 03:44 PM Licensed Nurse H stated IV antibiotics ordered every six hours should by given no closer than five hours apart. On 09/15/20 at 5:58 PM Administrative Nurse D stated the medications were expected to be given every six hours unless the physician had stated otherwise. On 09/17/20 at 09:43 AM Medical Consultant GG stated IV antibiotics are ordered for certain time frames due to the way they affect the body. Medications ordered for every six hours should not be given as close as every three hours. The facility's IV Administration policy dated November 2018 lacked documentation for the timeliness of IV medication administration. The facility failed to ensure R1's IV medications were administered, as ordered by the physician. This had the potential for ineffective antibiotic use and unwarranted side effects.