| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175344 | A. BUILDING _____ B. WING _____ | 05/18/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| SANDPIPER HEALTHCARE & REHABILITATION CENTER LLC | 5808 W 8TH STREET NORTH WICHITA, KS 67212 |

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 0600<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility census totaled 90 residents, with 13 included in the sample. Based on observation, interview, and record review the facility failed to prevent the neglect of 13 residents when Licensed Nurse (LN) C failed to provide competent nursing care during his shift from 07:00 PM on [DATE] through 07:00 AM on [DATE]. LN C reported consuming an unknown amount of Resident (R)1's [MEDICATION NAME] (an addictive narcotic pain medication) at an unknown time during his shift. Certified Nurse Aide (CNA) I found LN C sleeping at the nurse's station on [DATE] at approximately 06:15 AM, and then LN D found LN C asleep in R3's room at approximately 07:00 AM. The Electronic Medical Record (EMR) lacked documentation of provision of resident cares (including medication/treatment administration, resident assessments, and nursing notes) during his shift for Resident (R)1, R3, R4, R5, R6, R7, R8, R9, and R11.These cumulative failures led to the neglect of all 13 residents in his care (including one who died on his shift) and placed all 13 residents in immediate jeopardy . (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13) Findings included: - Interview on [DATE] at 01:23 PM with LN C revealed he began his shift on [DATE] at 07:00 PM with 13 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13) assigned under his care. When LN C began his shift, he received report from LN D, who informed him R1 readmitted to the facility on palliative care (end of life care). His assignment also included other residents that required varying assistance, medications, and treatments. Record review revealed nine residents assigned to LN C required the following care: 1. R1 required palliative care per Physician's Orders dated [DATE]. Review of R1's Care Plan dated [DATE] revealed no revision on return to facility on [DATE]. Review of an E-mail (electronic mail) from Physician Extender K to Administrative staff A dated [DATE] revealed LN C notified Physician Extender K on [DATE] at 10:06 PM that end of life care began for R1, oxygen saturation (oxygen in the blood) was in the 70th percentile (normal range ,[DATE]%), and the resident needed [MEDICATION NAME] for comfort. On [DATE] at 10:15 PM (3 hours and 15 minutes into LN C's shift) the physician's office responded with the order for [MEDICATION NAME] sulfate solution 20 milligrams (mg) per milliliter (ml), to administer 0.25 ml by mouth every one hour as needed (PRN) for comfort. Review of the [MEDICATION NAME] Narcotic Count Sheet for R1 dated [DATE] revealed the following documentation: 1. LN C signed out 0.25 ml of [MEDICATION NAME] at 10:00 PM (6 minutes before LN C called for an order) 2. LN C signed out 0.25 ml of [MEDICATION NAME] at 11:00 PM 3. LN C signed an entry on the [MEDICATION NAME] narcotic sheet which was illegible. Review of R1's [DATE] Medication Administration Record (MAR) lacked documentation of any PRN [MEDICATION NAME] administration from 10:00 PM on [DATE] to 07:00AM on [DATE]. Review of the EMR from [DATE] at 07:00 PM through [DATE] at 07:00 AM revealed lack of charting regarding R1 expiring until after LN C's shift ended and LN D charted a medication administration note entry noting R1 as deceased on [DATE] at 08:41 AM. Review of R1's EMR for blood pressure, pulse, oxygen saturations, and respirations revealed no documentation after return to the facility on [DATE] at 07:00 PM through [DATE] at 07:00 AM on LN C's shift. Interview with Certified Nurse Aide (CNA) E on [DATE] at 02:05 PM revealed on [DATE] when she and LN D came in to work at the facility, they heard a beeping sound and noticed the narcotic drawer was open on the medication cart in Express Recovery. When CNA E and the night shift CNA I were about to do rounds, CNA I said that someone died , and CNA E asked if anyone notified the family. CNA I said that was not her job. When CNA E and CNA I walked into R1's room the resident was in bed and covered in urine from head to toe. CNA I reported that she cleaned him up, but stated he clearly had urine all over. CNA I said R1 was in the same position as when the LN C positioned him the night before he died . CNA E and LN D notified Administrative Nurse F and Administrative Nurse F came back to the unit. CNA E observed LN C trying to call the family that morning, but he could not form words and his eyes were closing, so CNA E took the phone and talked to R1's family member. Interview with LN C on [DATE] at 01:23 PM revealed R1 had air hunger (struggling to breath) at 07:00 PM on [DATE] when he came on shift and the day shift nurse reported the resident did not have much longer to live. He said he called the doctor's office at 07:00 PM after he assessed R1 because he was alert to mild painful stimuli, not obeying commands, had his mouth wide open with dry oral secretions, concerning lung sounds, and was pale. LN C did not remember what R1's vital signs were, but it was evident that he was at the end of his life. LN C reported that he had 13 residents he was caring for that night and had written the doses of R1 administered [MEDICATION NAME] doses on a notepad and was not sure why he did not document those doses or sign them out. He stated at 04:00 AM on [DATE], he noticed R1 passed away and attempted to call the family but did not document it in the resident's chart. At 04:30 AM, he took a little sip of R1's [MEDICATION NAME] and stated he then passed his residents' their morning medications. He did not remember being asleep at the nurse's desk that morning or when the morning nurse found him leaning on the side of R3's bed with the feeding tube pole teetering between himself and the wall. The LN D woke him up, he tried to give report on all residents and count narcotics, and reported he left the facility after that. He stated he administered eight doses of the [MEDICATION NAME] to R1 and reported that he called the doctor's office for the [MEDICATION NAME] at 08:00 PM on [DATE]. LN C said he administered a dose of [MEDICATION NAME] to R1 at 08:00 PM on [DATE] and every hour until 03:00 AM on [DATE]. 2. Review of R3's Quarterly Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of two indicating severely impaired cognition. The assessment noted R3 had a feeding tube (tube into the stomach for nourishment) providing 51% or more nutrition and 501 cubic centimeters (cc) or more of fluids. R3 required extensive assistance of two staff for all activities of daily living (ADLs). Review of the Care Plan dated [DATE] revealed R3 had a risk for respiratory complications due to a [MEDICAL CONDITION] (a tube into the windpipe to assist with breathing) as evidenced by hypoxic episodes (low levels of oxygen). R3 required continuous oxygen. Nursing staff were to monitor oxygen saturation levels and report, as indicated. Staff were to provide [MEDICAL CONDITION] care as necessary and ensure [MEDICAL CONDITION] ties were secured, with suctioning as needed. R3 required tube feedings related to a swallowing problem and the resident was dependent with tube feeding and water flushes. R3 had a Low Air Loss (LAL) Mattress to prevent pressure areas. Review of Physician Orders dated [DATE] revealed R3 with a feeding tube site. Staff were to cleanse the site with wound cleanser/normal saline (NS), pat dry, apply T-sponge (gauze pad with a slot cut out for the tube), and secure with tape. Staff were to change nightly and PRN every night shift. Review of the MAR for [DATE] revealed lack of peg tube site documentation on [DATE] at bedtime. Notarized Witness Statement by LN D on [DATE] revealed she found LN C on R3's bed asleep with R3 also in the bed. LN D noted the feeding tube knocked over and the bed air mattress deflated. LN C was sweating profusely, flustered, and tried to assemble the feeding tube. LN D observed the narcotic drawer open and a [MEDICATION NAME] bottle on the floor under the medication cart located in Express Recovery. Observation of R3 on [DATE] at 04:30 PM revealed the resident laid on his back with the head of his bed elevated. The resident had a feeding tube running on a pump with the container full. The resident had a [MEDICAL CONDITION] with oxygen running via [MEDICAL CONDITION]. The resident appeared clean with no odors of incontinence present. The resident had a functioning air mattress on his bed. Interview with CNA E on [DATE] at 02:05 PM revealed on the morning of [DATE] CNA E |

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 0600

**Level of harm -** Immediate jeopardy

**Residents Affected -** Some

(continued... from page 1)
noted R3's bed completely saturated with urine, R3 had a bowel movement, and it was evident the resident had not been cared for during the night shift. Interview with LN D on [DATE] at 12:54 PM revealed she got to work [DATE] at 07:00 AM and found LN C in R3's room and woke him. LN C told her that he came into R3's room because he heard the beeping and the feeding tube was undone, so he tried to fix it. LN D recalled R3's air mattress was deflated, so LN D plugged the air mattress back in and placed R3's oxygen back on his [MEDICAL CONDITION]. Once that was done, LN D assessed R3's oxygen level, which was 90%, and assessed for pain to which he did not look in distress or uncomfortable. 3. The [DATE] Admission MDS revealed R4 had a BIMS score of 10, indicating moderate cognitive impairment. R4 required extensive assistance of two staff with ADLs. R4 rarely complained of pain, had very poor vision, and did not wear glasses. The resident was dependent on [MEDICAL TREATMENT] (a blood purifying treatment given when kidney function is not optimum). Review of [DATE] Care Plan revealed: Revision [DATE]- Resident requirement for transfer: Extensive assistance of one to two staff. Revision [DATE]- Staff were to check and change to maintain dignity for R4. Revision [DATE]- R4 had very poor vision and he did not wear glasses. Revision [DATE]- Due to poor vision, the resident was unable to see button on call light in order to request staff assist with transfers. Resident given a push pad call light, was able to demonstrate effective use several times, and properly used call light twice throughout remainder of shift. Revision dated [DATE] revealed R4 received [MEDICAL TREATMENT] related to [MEDICAL CONDITION] (kidney disease). Review of R4's [DATE] MAR lacked documentation of the ordered finger stick blood glucose (BG) checks at 06:00 AM on [DATE] and lacked documentation of R4's hours of sleep on the night shift [DATE] to [DATE]. Observation of R4 on [DATE] at 04:23 PM revealed the resident sat in a recliner with legs elevated. R4's walker was beside the recliner and the call light was on the chair. Interview with CNA E on [DATE] at 02:05PM revealed on [DATE] when she walked into R4's room there were two unidentified pills in a medication cup sitting on his side table. CNA E told R4 not to touch them and CNA E got LN D and LN D disposed of the pills. During an interview on [DATE] at 01:57 PM, LN D reported when she came on shift the morning of [DATE] CNA E reported a cup with two unidentified pills on the nightstand of R4's room. The nurse picked them up and destroyed them. 4. Review of R5's [DATE] Admission MDS revealed R5 had no speech, was rarely/never understood, and rarely/never understood others. The MDS noted the resident had severely impaired cognitive skills for daily decision making. R5 required total assistance of two or more staff for all ADLs. R5 had an indwelling urinary catheter, required oxygen, oral suctioning, and [MEDICAL CONDITION] care. Review of [DATE] Care Plan revealed R5 required total assistance for ADLs. Staff were to monitor lung sounds as needed. Staff were to provide [MEDICAL CONDITION] care as necessary and [MEDICAL CONDITION] (strings to anchor the [MEDICAL CONDITION]) were secured, suction as needed, and noted the resident had an indwelling catheter (a tube placed into the bladder to drain urine). R5 required tube feedings related to dysphagia (difficulty swallowing). Review of oxygen saturations in the EMR revealed no oxygen level recorded for the night shift of [DATE] to [DATE]. Review of R5's MAR for [DATE] revealed staff did not administer his 06:00 AM dose of [MEDICATION NAME] 0.5 mg on [DATE], to be given by feeding tube every 8 hours for anxiety/agitation (started on [DATE] per physician order). R5 did not receive his 06:00 AM dose of [MEDICATION NAME] tablet 10 mg on [DATE], to be given via feeding tube three times a day for muscle spasms (started on [DATE]). R5's midnight dose of [MEDICATION NAME]-[MEDICATION NAME] solution 0XXX,[DATE].5 (3) mg/3ml, 3 ml by [MEDICAL CONDITION] every 6 hours, for shortness of breath/wheezing was marked as a y and signed as given by LN C, however no minutes were recorded and the 06:00 AM on [DATE] treatment was not administered per the MAR as ordered per physician orders on [DATE]. The resident's [DATE] at 11:00 PM enteral feeding order for every four hours for nutrition via bolus: [MEDICATION NAME] (liquid nutrition) 1.5 can every four hours by feeding tube was not administered and neither was the [DATE] 03:00 AM administration. The associated [DATE] at 11:00 PM and [DATE] at 03:00 AM enteral feed flush of water before and after feedings of 75 ml were not administered as ordered on physician orders dated [DATE]. R5 did not receive his physician ordered (dated [DATE]) flushes to his [MEDICAL CONDITION] with saline and suction every 4 hours for prevention of mucus plug on [DATE] at 12:00 AM or 04:00 AM. Observation of R5 on [DATE] at 04:33 PM revealed the resident laid on his back with head and feet elevated. The resident had a [MEDICAL CONDITION] with oxygen running at 5 liters per [MEDICAL CONDITION]. 5. Review of R6's [DATE] Care Plan revealed R6 required extensive assistance of two staff for transferring and toilet use. Review of R 6's Physician Orders included: [DATE] [MEDICATION NAME] (narcotic pain medication) ,[DATE] milligrams (mg), give two tablets by mouth every four hours as needed for severe pain. [DATE] [MEDICATION NAME] ,[DATE] mg, give one tablet by mouth every four hours as needed for moderate pain. [DATE] pain monitoring- every shift; Review of [DATE] MAR and Treatment Administration Record (TAR) lacked documentation for the night shift of [DATE]. [DATE] [MEDICATION NAME] ([MEDICAL CONDITION] replacement hormone) 112 micrograms (mcg), give 112 mcg by mouth one time a day for [MEDICAL CONDITION]. Review of [DATE] MAR lacked documentation of administration on [DATE] at 06:00 AM. Observation of R6 on [DATE] at 04:16 PM revealed the resident rested in bed with the head of bed elevated. The resident had his walker beside the bed. 6. Review of R7's [DATE] Care Plan revealed R7 required supervision with toileting and transfer. Review of the [DATE] Admission MDS revealed a BIMS score of 14, indicating intact cognition. The resident required extensive two-person assistance for transfers and toilet use, unsteady balance, impaired range of motion on one side of the lower extremities and used a walker and wheelchair for mobility. The resident required PRN pain medications and nonpharmacological interventions for frequent pain that limited day-to-day activities and sleep. The resident rated the pain as a 7 on a scale of 0 to 10, with 10 being the worst pain. Physicians Orders dated [DATE] revealed R7 required pain monitoring every shift, however the [DATE] MAR lacked evidence of pain documentation on night shift for [DATE]-[DATE]. Physicians Orders dated [DATE] directed staff to monitor hours of sleep each shift for evaluation of medications used to treat [MEDICAL CONDITION]. Review of [DATE] MAR lacked documentation of sleep on the night shift on [DATE] to [DATE]. Physicians Orders dated [DATE] for behavior monitoring stated, if behaviors were present, a progress note had to be completed every shift. Review of [DATE] MAR lacked documentation of behaviors on night shift [DATE] to [DATE], related to the one-time dose of [MEDICATION NAME] (antianxiety medication) noted below. Physicians Orders dated [DATE] at 08:30 PM revealed [MEDICATION NAME] (antianxiety medication) 1 mg, give 1 mg by mouth one time only for anxiety. Review of [DATE] MAR revealed LN C administered this one-time order at 08:43 PM. Physicians Orders dated [DATE] for [MEDICATION NAME] ([MEDICATION NAME] with calming effects) 25 mg, give 25 mg by mouth every 6 hours for anxiety. Review of [DATE] MAR revealed missed documentation of 06:00 AM scheduled dose on [DATE]. Physicians Orders dated [DATE] at 06:00 AM revealed [MEDICATION NAME] 0.5 mg ordered on [DATE], give 0.5 mg by mouth four times a day for anxiety. Review of [DATE] MAR revealed missed documentation of 06:00 AM scheduled dose on [DATE]. Review of Pain Scale Assessments for [DATE] lacked evidence of documentation from [DATE] to [DATE] on the night shift. Observation of R7 on [DATE] at 04:18 PM revealed an alert resident watching TV in her room. 7. Review of R8's [DATE] Care Plan revealed the resident had a tendency to exhibit behavior issues such as resistive to care and potential to be aggressive towards others. The care plan instructed staff to administer medications as ordered. R8 required limited assistance of one staff with ADLs. Revision dated [DATE] revealed the resident wore Continuous Positive Airway Pressure ([MEDICAL CONDITION], apparatus worn with a mask to keep airways open during sleep) for sleep apnea (disorder of sleep characterized by periods without respirations). Review of Physician Orders dated [DATE] regarding pain monitoring, instructed staff to code pain interventions and address pain for R8 every shift. Review of the [DATE] MAR and TAR lacked evidence of documentation for pain assessments on [DATE] to [DATE] on the night shift. Review of Physician Orders dated [DATE] revealed [MEDICATION NAME] (medication used to treat low blood pressure) 5 mg, administer by mouth three times a day for [MEDICAL CONDITION] (low blood pressure). Review of the [DATE] MAR revealed missing documentation for [DATE] at 06:00 AM. Review of Physician Orders dated [DATE] revealed an order for [REDACTED]. Review of [DATE] MAR and TAR revealed no documentation for behavior monitoring on the [DATE] to [DATE] night shift. 8. Review of R9's Admission MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. The resident required assistance of one person with ADLs and toileting. Review of the Physician Orders dated [DATE] and corresponding MAR revealed on [DATE] the 06:00 AM blood sugars were not recorded as done as ordered, and the resident did not receive insulin or oral antidiabetic medications. 9. Review of R11's Admission MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognition. Review of R11's Care Plan dated [DATE] revealed [MEDICAL CONDITION] (kidney disease) requiring [MEDICAL TREATMENT]. Staff were to monitor during ADLs for sign/symptoms of shortness of breath. Staff were to monitor/document/report any signs or symptoms of bleeding, swelling, redness, warmth at access site upon returning from [MEDICAL TREATMENT]. Staff were to provide relief of discomfort from side effects of disease and treatment and take medications as ordered. Revision dated [DATE] directed staff to encourage and educate R11 to follow a fluid restriction. Review of the MAR for [DATE] revealed on [DATE] an order for [REDACTED]. Review of the MAR dated [DATE] indicated the resident received Basaglar (long acting insulin) eight units at 08:00 PM. Review of the MAR for [DATE] revealed the resident always wore a life vest (external defibrillator - treatment for [REDACTED]. The clinical record lacked evidence of documentation staff changed the battery on [DATE] from 07:00 PM through [DATE] at 07:00 AM, as ordered. Review of the MAR

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| F 0600<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 2)<br>for [DATE]-[DATE] revealed an order for [REDACTED]. The MAR lacked documentation of completion of the order on the [DATE]<br>07:00 PM through [DATE] at 07:00 AM shift. Review of the MAR for [DATE] included an order to monitor sleep at night. There was no documentation of completion on the [DATE] 07:00 PM to [DATE] 07:00 AM shift. Observation on [DATE] at 04:40 PM revealed the resident laid in his bed on his back with the head of bed elevated. The resident rested quietly with a wheelchair beside his bed. The resident wore his life vest. Interview with CNA E on [DATE] at 02:05PM revealed on [DATE] when she and LN D arrived for the shift on [DATE], they heard a beeping sound and the medication cart was unlocked and the narcotic drawer was open on the Express Recovery. When they went towards the beeping in R3's room, LN C was in R3's room. LN D awakened LN C, who then tried to pick up the feeding tube and put it back together. While LN C was doing so, LN D placed the supplemental oxygen back on R3's [MEDICAL CONDITION]. When CNA E and the night shift CNA I were about to do rounds, she mentioned that a resident died . CNA E asked if anyone notified the family and CNA I said that was not her job. When the CNAs walked into R1's room, the resident was in bed and saturated in urine from head to toe. CNA I reported that she cleaned him up, but he clearly had urine all over. CNA E and LN D notified Nurse F because no one had been notified, and LN F came back to the Express Recovery unit. CNA E observed LN C attempt to call the family that morning, but he could not form words and his eyes were closing. CNA E stated Administrative Nurse F walked LN C out of the building at approximately 08:,[DATE]:45AM on [DATE]. R2 complained of pain to CNA E, saying his call light had not been answered all night, he said Thank God, the night shift nurse had not been in to help him with pain. There were two other residents, R3 and R5, that had beds that were completely wet with urine, and R3 had a bowel movement. During an interview on [DATE] at 12:54 PM LN D revealed she arrived to work at 07:00 AM on [DATE] and found LN C in R3's room sleeping. When she arrived on the unit, the feeding tube pump in R3's room was beeping because it was empty. The feeding was to run from 03:00 PM on [DATE] to 11:00 AM on [DATE]. She also noticed the narcotic drawer was left open in the medication cart on the Express Recovery. She then went towards the beeping, found LN C leaning, sleeping on R3's bed, and woke him. LN C told her that he came into R3's room because he heard the beeping and the feeding tube was undone, so he tried to fix it. R3's oxygen was off R3's [MEDICAL CONDITION] and the air mattress deflated, so LN D plugged the air mattress back in and placed R3's oxygen back on his [MEDICAL CONDITION]. LN D assessed R3's oxygen levels, which was 90% and assessed pain, but he did not have signs or symptoms of distress or discomfort. LN C's glasses were on the floor, so LN D picked them up and she noticed R1's [MEDICATION NAME] bottle under the medication cart, then placed it on top of the medication cart. LN D reported that during that time, LN C walked into multiple resident rooms and tried to walk to the bathroom. LN D then went to get Administrative Nurse F and told her about LN C's behavior, reporting LN D was off the unit about five minutes. LN D then returned to Express Recovery and attempted to count narcotics with LN C, and LN D reported LN C could not see or write. LN C then went to the bathroom again. LN D looked over the narcotic count (detailed audit of the quantity of the current stock of a drug on hand compared with the amount dispensed to determine any losses or overages) and noted that the [MEDICATION NAME] for R1 was wrong. The [MEDICATION NAME] bottle for R1 had 24cc left when she found the bottle with 6 cc missing (120 mg). Administrative Nurse F verified R1's [MEDICATION NAME] sulfate count. LN C reported to LN D that he tried to call R1's family about his death. LN D did not suspect impairment with LN C until LN D noticed the [MEDICATION NAME] balance was wrong. Interview on [DATE] at 05:05 PM with Administrative Nurse F revealed she became involved with the incident when LN D told her the narcotic count was wrong. Administrative Nurse F approached the medication cart while LN C and LN D counted the narcotics. Everything was okay until they counted the liquid [MEDICATION NAME] for R1, and it did not measure right. Administrative Nurse F looked at the [MEDICATION NAME] bottle and compared it to the count sheet. LN C attempted to document doses given on the narcotic sheet. Administrative Nurse F took the count sheet and asked LN C how often he gave it throughout the night. He told her he gave 0.25 ml every hour. When asked when the last dose was given, he could not answer. Administrative Nurse F asked him where the rest of the [MEDICATION NAME] was, and he could not account for the missing [MEDICATION NAME]. She asked LN C if he gave his drug keys to anyone during the shift and he reported he did not. Administrative Nurse F reported she wrote out what the [MEDICATION NAME] should have been if LN C gave it like he said and there was still missing [MEDICATION NAME]. That conversation took ,[DATE] minutes due to LN C not understanding, falling asleep, and slurred speech. LN C became very agitated with questions and denied taking the medication. He became very disruptive and argumentative with Administrative Nurse F, so she told him to gather his belongings and leave. LN C could not walk straight and kept getting in front of Administrative Nurse F asking her not to call Administrative Nurse B repeating this over and over, and insisted he was not impaired. He clocked out and exited the building. Administrative Nurse F stepped out and saw LN C walking at the edge of the parking lot and at that point she called Administrative Nurse B. Administrative Nurse B took over from there while LN C was still in parking lot. Interview with Administrative Nurse B on [DATE] at 04:45 PM revealed she did not know there was no documentation for the extra [MEDICATION NAME] for R7's behaviors. When asked when she was notified of the situation, she reported Administrative Nurse F called her and she was at the facility in 20 minutes. Administrative Nurse B stated, she would have expected documentation for pain, any assessments and cares from nurses, CNAs, or any other employee that had information on residents and observations of staff. Review of the facility policy Provision of Care dated 2019 revealed each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being. Qualified persons will provide the care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices. All employees are responsible for following established policies and procedures. Review of the Documentation in Medical Record policy dated ,[DATE] revealed: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation. Licensed staff and interdisciplinary team members shall document assessments, observations, and services provided in the residents' medical record in accordance with state law and facility policy. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Review of the facility policy Providing End of Life Care dated [DATE] revealed assessment and evaluation may be documented by multiple members of the interdisciplinary team (e.g. nurses, practitioner, social worker, dietician, etc.). The facility failed to prevent the neglect of 13 residents when Licensed Nurse (LN) C failed to provide necessary nursing care during his shift from 07:00 PM on [DATE] through 07:00 AM on [DATE] which constituted immediate jeopardy at F600. The immediate jeopardy at F600 also constituted Substandard Quality of Care at 42 CFR 483.12. The immediate jeopardy was determined to first exist on [DATE], when LNC received report and assumed responsibility for multiple residents which required complex nursing care. LN C consumed R1's [MEDICATION NAME] at an undetermined time and cared for his assigned residents while impaired. The deficient practice was cited as past non-compliance when LN C left the building [DATE], the facility reconciled all medication carts, reassessed pain for all residents under the care of LN C, and provided education on [DATE] to anyone starting there shift on Reporting of erratic behavior of other employees. The deficient practice remained at a scope and severity of K. |
| F 0602<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Protect each resident from the wrongful use of the resident's belongings or money.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility census totaled 90 residents, with 13 residents in the Express Recovery. Based on interview and record review the facility failed to prevent the missappropriation of Resident (R)1's [MEDICATION NAME] (an addictive opioid medication used to treat moderate to severe pain) when Licensed Nurse (LN) C consumed an unknown quantity of R1's [MEDICATION NAME] during an unspecified time during his shift between 05/01/20 at 07:00 PM until 05/02/20 at 07:00 AM. The misappropriation of R1's [MEDICATION NAME] by LN C placed the 13 residents under his care in immediate jeopardy. Findings included: - Review of R1's Electronic Medical Records (EMR) included a diagnosis, dated 05/01/20, of cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). Review of 01/29/20 Quarterly Minimum Data Set (MDS) revealed a Brief Interview for Mental Status (BIMS) of two indicating severely impaired cognition. The resident had scheduled pain medications for mild, occasional pain that limited day-to-day activities when present and daily opioid (narcotic pain medication) used in the seven-day review period. Review of the Care Plan revised on 04/08/19 directed staff to monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. Review of Physician order [REDACTED]. 05/01/20 at 10:15 PM revealed an order for [REDACTED]. Review of the Narcotic Count Sheet for R1, dated 05/01/20, revealed one documentation of 0.25ml given at 10:00 PM and 0.25ml dose given at 11:00 PM. The third documentation was not legible. Review of LN C's Witness Statement dated 05/01/20 reported that he administered a total of eight doses of the [MEDICATION NAME]. There was no documentation that R1 received the remaining five doses of [MEDICATION NAME]. Review of an E-mail (electronic mail) from LN D to Administrative staff A dated 05/04/20 revealed LN D completed the end of shift report with LN C with the following information: R1 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175344 | A. BUILDING _____ B. WING _____ | 05/18/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| SANDPIPER HEALTHCARE & REHABILITATION CENTER LLC | 5808 W 8TH STREET NORTH WICHITA, KS 67212 |

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 0602<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 3)<br>transferred to the behavioral unit for evaluation, and then transported from there to the hospital with a [DIAGNOSES REDACTED]. R1 was in a stuporous (lacked critical mental function and level of conciousness) state, not responding to verbal or tactile stimuli, and no facial grimacing. LN C asked LN D if R1 had orders for [MEDICATION NAME] or [MEDICATION NAME] (medication used to treat anxiety). R1 had orders for [MEDICATION NAME] and [MEDICATION NAME] (a narcotic pain medication), but not for [MEDICATION NAME]. LN D relayed to LN C that R1 had no indicators of pain since he arrived back at the facility. LN D told oncoming LN C to check R1 frequently due to his condition. Review of R1's EMR for the tweleve hour 7 PM - 7 AM shift on 05/01/20 to 05/02/20 lacked evidence of nursing notes, nursing assessments of the resident, or completion of pain assessments. Review of an E-mail from Physician Extender K to Adminitstrative staff A dated 05/04/20 revealed LN C notified physician extender K on 05/01/20 at 10:06 PM that end of life care began, and oxygen saturation (oxygen in the 70th percentile (normal range 92-100%) and the resident needed [MEDICATION NAME] for comfort. Review of the 05/02/20 Facility Investigation revealed the witness statement completed by LN C stated, R1 received approximately eight doses and passed away. That was when I, (LN C), took some oral ([MEDICATION NAME]) by mouth and do not<br>remember much after that. The facility reported incident identified 6 ml of [MEDICATION NAME] sulfate unaccounted for, which equaled to 120 mg of [MEDICATION NAME]. Interview with Certified Nurse Aide (CNA) E on 05/13/20 at 02:05 PM revealed<br>on 05/02/20 when she and LN D came on shift, they heard a beeping sound and noticed the narcotic drawer was open on the medication cart. When they went to the beeping in R3's room, LN C attempted to pick up the feeding tube and put it back together and hook oxygen to the resident. Interview with CNA G on 05/14/20 at 07:13 PM revealed on 05/02/20 at approximately 07:10 AM when he got to the Express Recovery Unit was that LN C was sweating a lot and he looked tired. Interview with LN C on 05/13/20 at 01:23 PM revealed R1 had air hunger at 07:00 PM on 05/01/20 when he had come on shift and the day shift nurse reported he did not have much longer to live. He reported that he called the on call physician on 05/01/20 at 07:00 PM after he assessed R1 because he was alert to mild painful stimuli, not obeying commands, had his mouth wide open with dry oral secretions, concerning lung sounds, and was pale. LN C did not remember what R1's vital signs were, but said it was evident that he was at the end of his life. He then stated maybe he called the doctor's office for the [MEDICATION NAME] at 08:00 PM on 05/01/20, but he did give eight doses of the [MEDICATION NAME] to R1. LN C said he administered to R1 a dose of [MEDICATION NAME] at 08:00 PM on 05/01/20 and every hour until 03:00 AM on 05/02/20. He stated at 04:00 AM on 05/02/20, he noticed R1 had passed away. At 04:30 AM, he took a little sip of R1's [MEDICATION NAME]. LN C<br>reported this was the first time he had slipped up in two years and eight months. He had no idea why he drank R1's [MEDICATION NAME]. He stated he had not ever stolen from a resident at the facility. During an interview with LN D on 5/11/2020 at 07:25 AM revealed she came on duty for the day shift on 05/02/2019 to work the unit. When she arrived, LN C was acting like he was really out of it. Both tried to count narcotics, but he was sweating, could not focus on counting, and there was a problem with missing [MEDICATION NAME]. During an interview with LN D on 05/13/20 at 12:54 PM revealed she<br>got to work at 07:00 AM and found LN C sleeping in R3's room. LN D woke LN C and noticed he was slurring his words and confused. LN D noticed that LN C glasses were on the floor, and when she picked them up, she noticed R1's [MEDICATION NAME] bottle under the medication cart and placed the [MEDICATION NAME] bottle on top of the medication cart. She reported during that time, LN C walked in and out of multiple resident rooms and tried to walk to the bathroom. When she attempted to count narcotics with LN C, he could not see or write. He then went to the bathroom again, and while he was gone, LN D looked over the narcotic count and noted the [MEDICATION NAME] for R1 was off from count sheet. The [MEDICATION NAME] bottle for R1 had 24 ml left out of 30 ml when she found the bottle. Interview with Administrative Nurse F on 05/13/20 at 05:05 PM revealed she got involved with the incident when LN D told her the narcotic count was off. She approached the medication cart while LN C and LN D were counting the narcotics. Everything was okay until they counted the liquid [MEDICATION NAME] for a resident, and it did not measure right. When she got there, she looked at the bottle and compared it to the count sheet. LN C then attempted to document doses given on the narcotic sheet. Nurse F then asked LN C how often he administered the [MEDICATION NAME] to R1 throughout the night and LN C told her he had given 0.25 ml every hour. When Nurse F asked LN C when he administered the last dose of [MEDICATION NAME] to R1 and why there was missing [MEDICATION NAME], LN C could not<br>answer or account for the missing [MEDICATION NAME]. Nurse F then asked LN C if he had given his drug keys to anyone during the shift and he reported he did not. Nurse F reported she wrote out what the [MEDICATION NAME] should have been if LN C gave it like he said, but stated there was still missing [MEDICATION NAME]. Nurse F said the conversation took 20-30 minutes due to LN C not understanding questions, slurring his speech, and not able to keep his eyes open. LN C was very disruptive, argumentative, agitated with questions, and denied consuming the medication. Nurse F instructed LN C to gather his belongings, but LN C could not walk straight and kept standing in front of Nurse F asking her not to call Administrative Nurse B, repeating the sentence over and over. Interview with Administrative Nurse B on 05/11/20 at 05:20 AM revealed on 05/02/20 LN D and Administrative Nurse F attempted to stop LN C from leaving the facility, but he walked outside to the parking lot between two cars and fell . He continued to fall while attempting to ambulate. Administrative Nurse B called Emergency Medical Services (EMS), and two doses of [MEDICATION NAME] (medication that reverses narcotics) were administered to LN C. After the two doses he became more alert but still had signs of impairment. During a follow-up interview with Adminstrative Nurse B on 05/14/20 at 04:45 PM revealed after identification of the missing [MEDICATION NAME], Nurse F held onto the [MEDICATION NAME] until placement in the secured lockbox by 10:00 AM on 05/02/20. Nurse B questioned LN C about the signs and symptoms of R1, and it was evident from LN C assessment of R1 that the resident needed the [MEDICATION NAME] for comfort. She did not know if R1 got all the doses that LN C said he gave. She hoped he did get those doses. Review of 2017 Resident Right to Freedom from Abuse, Neglect, and Exploitation Policy and Procedure policy revealed Recover Care explicitly and expressly prohibits, and will take steps to prevent, any Associates from engaging in any behavior or actions that may result in the abuse, neglect, and exploitation of residents and misappropriation of resident property. Review of revised 10/2017 The Elder Justice Act and Reporting Suspected Crimes Against Residents Policy and Procedure policy revealed exploitation was defined as the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for personal benefit or gain. The facility failed to ensure R1's [MEDICATION NAME] was not misappropriated by LN C when the facility discovered LN C consumed R1's [MEDICATION NAME] at an unknown time during his shift. LN C was responsible for 13 residents<br>and cared for these residents while impaired.which placed the 13 residents under his care in immediate jeopardy. The deficient practice was cited as past non-compliance when LN C left the building, the facility reconciled all medication carts, reassessed pain for all residents under the care of LN C, and provided education on 05/02/20 to anyone starting there shift on Reporting of erratic behavior of other employees. The deficient practice remained at a scope and severity of J. |