STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175214	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF CHANUTE	**530 W 14TH STREET CHANUTE, KS 66720**

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 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 17 residents sampled, including one resident reviewed for hospitalization . Based on interview and record review, the facility failed to provide the one sampled Resident (R) 31, with a written notice specifying the duration of the bed-hold policy, at the time of the resident's transfer to the hospital. 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 she had intact cognition. The quarterly MDS, dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she had intact cognition. Review of the resident's medical record in Point Click Care (PCC), an electronic documentation system, under the Progress Notes tab revealed the resident admitted to the hospital from the facility on 04/30/20, with a [DIAGNOSES REDACTED]. On 08/26/20 at 01:48 PM, the resident stated she admitted to the hospital due to her INR levels becoming too high. She was not given a bed-hold before being admitted to the hospital. On 08/31/20 at 04:00 PM, Licensed Nurse (LN) G stated when a resident goes to the hospital, the business office manager will ensure the bed-hold was complete. On 09/01/20 at 09:30 AM, administrative staff B stated, the nurses are responsible for ensuring bed-hold policies are sent out with the resident when they are admitted to the hospital. On 09/01/20 at 08:38 AM, Administrative Nurse D stated, she was unsure if bed-holds were being sent out when a resident admitted to the hospital. This was something the nurse would be responsible for. The facility policy for Bed Hold, effective 11/01/16, included: Before the center transfers a resident to the hospital, the center shall provide the resident or her resident representative with the bed hold policy. The facility failed to provide the resident with a bed-hold at the time of her transfer to the hospital.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 17 residents included in the sample. Based on observation, interview, and record review, the facility failed to complete an accurate comprehensive assessment for two of the sampled residents, including Resident (R) 44, related to limited range of motion (ROM) and R49 for administration of psychotrophic medications. Findings included: - The Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for dressing and total assistance of one staff for personal hygiene. She had no impairment in functional range of motion (ROM) of the upper extremities and had bilateral impairment in ROM of the lower extremities. The Care Area Assessment for Activities of Daily Living (ADL), dated 01/24/20, did not trigger for further review. The quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for dressing and personal hygiene. She had no impairment in functional range of motion (ROM) of the upper extremities and bilateral impairment in ROM of the lower extremities. Review of the resident's medical record in Point Click Care (PCC), under the Minimum Data Set (MDS) tab, revealed MDSs completed on 03/13/20 and 05/15/20, which also documented the resident had no limitation in range of motion (ROM) in her upper extremities. The Activities of Daily Living Care Area Assessment (CAA), dated 08/25/20, instructed staff the resident was dependent on two staff for bed mobility. On 08/26/20 at 08:51 AM, the resident sat in the dining room in her geri-chair (specialized wheelchair with a high back). Resident had both shoulders pulled up with elbows held closely to her sides, contracted (abnormal permanent fixation of a joint). On 08/27/20 at 11:18 AM, Certified Nurse Aides (CNA) TT and N gave cares to the resident while she was in her bed. The resident continued to hold her arms tightly to her sides. On 08/26/20 at 02:30 PM, the resident's family member stated the resident had contractures in her shoulders and arms when she first admitted to the facility. On 08/31/20 at 07:13 AM, CNA M stated, the resident's shoulders are contracted. On 08/31/20 at 09:53 AM, CNA N stated, the resident had contractures in her arms and shoulders. On 09/01/20 at 07:47 AM, Administrative Nurse E stated, the resident had contractures to her upper extremities. The MDSs, dating 01/24/20, 03/13/20, 05/15/20, and 08/13/20, documenting the resident had no limited ROM in the upper extremities were inaccurate. On 09/01/20 at 10:15 AM, Administrative Nurse D stated, it was her expectation that the MDSs be completed accurately. The facility follows the Resident Assessment Instrument (RAI) manual for accurate completion of the MDS. The facility failed to complete an accurate comprehensive assessment for this dependent resident with limited ROM in both upper extremities. - The signed Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident admitted [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0 as resident is rarely/never understood. His cognition was severely impaired. The resident received antipsychotics for seven days of the look back period. Antipsychotics were not received. The [MEDICAL CONDITION] (relating to or denoting drugs that affect a person's mental state) Drug Use Care Are Assessment (CAA) dated 05/12/2020, documented the resident had severe dementia and was aggressive. The revised care plan for [MEDICAL CONDITION] medication, dated 08/21/2020, instructed staff that R49 was on [MEDICATION NAME] (antipsychotic medicine that works by changing the effects of chemicals in the brain) related to behavior management . The POS, dated and signed on 07/14/2020, documented the following orders: [MEDICATION NAME] 1 Milligram (mg), twice a day for sexually and aggressive behaviors, ordered on [DATE] On 09/01/2020 at 07:47 AM, Administrative Nurse E confirmed the MDS was inaccurate. On 09/01/2020 at 01:10 PM, Administrative Nurse D reported the expectation would be the MDS should be accurate. The facility lacked a policy for MDS, however, the facility followed the Resident Assessment Instrument (RAI) manual for the MDS. The facility failed to accurately complete the MDS in regards to antipsychotic medications.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents, with 17 residents sampled. Based on observation, interview, and record review, the facility failed to develop an individualized comprehensive plan of care for two of the sampled Residents, (R) 44 regarding restorative care and R 27 regarding oxygen therapy. Findings included: - The Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for dressing and total assistance of one staff for

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) personal hygiene. She had no impairment in functional range of motion (ROM) of the upper extremities and bilateral impairment in ROM of the lower extremities. She received passive range of motion (PROM) one day of the assessment period. The Care Area Assessment for Activities of Daily Living (ADL), dated 01/24/20, did not trigger for further review. The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for dressing and personal hygiene. She had no impairment in functional range of motion (ROM) of the upper extremities and bilateral impairment in ROM of the lower extremities. She did not receive any restorative services during the assessment period. The Restorative Care Plan, dated 12/16/19 and revised 08/25/20, instructed the staff to perform PROM, but lacked instructions of what PROM to perform, how many repititions and how many days the staff should provide the resisent with restorative care. On 08/26/20 at 08:51 AM, the resident sat in her geri-chair (high back specialized wheelchair). The resident's bilateral shoulders pulled up with her elbows and wrists contracted (abnormal permanent fixation of a joint). On 08/27/20 at 11:20 AM, Certified Nurse Aide (CNA) TT and CNA N positioned the resident in the bed. Staff have a difficult time straightening the resident's shirt due to her arms being held tightly against her torso and her elbows being difficult to open. Staff failed to complete PROM with the resident. On 08/31/20 at 07:13 AM, CNA M and Q dressed the resident for the day. Staff explained they have a difficult time getting the resident's shirt on due to her upper extremities being tight. Staff failed to complete PROM with the resident. On 09/01/20 at 07:47 AM, Administrative Nurse E stated, the care plan should include individualized restorative care for each resident. This resident's care plan was not individualized in regards to restorative care. On 09/01/20 at 10:15 AM, Administrative Nurse D stated, care plans should be individualized for each resident. The facility lacked a policy for care plans. The facility failed to complete an individualized care plan for this dependent resident regarding restorative services. - The Physicians Order Sheet (POS), dated 08/19/20, documented Resident (R) 27 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 8, indicating she had moderately impaired cognition. She required oxygen usage, total assist of two staff for personal hygiene and had limited range of motion (ROM) on one side of her upper extremities. The Care Area Assessment, dated 07/17/20, did not mention the resident's oxygen usage. The Care Plan, dated 07/29/20, lacked staff instruction regarding oxygen use or proper cleaning of the oxygen concentrator machine. Review of the resident's medical record in Point Click Care (PCC), an electronic documentation system, under the Orders tab revealed a physician order [REDACTED]. The oxygen concentrator filter contained a heavy build-up of dust and debris. On 08/31/20 at 09:00 AM, Certified Nurse Aide (CNA) M was unsure if the filters to the oxygen concentrators were cleaned at on Sunday nights when staff changed the tubing. On 08/31/20 at 04:00 PM, Licensed Nurse (LN) G stated, the night nurse would change the oxygen tubing weekly. Staff G did not know about the cleaning of the oxygen concentrator filters. On 09/01/20 at 11:07 AM, Administrative Nurse D stated, the oxygen tubing needed to be changed weekly and the concentrator filters needed to be cleaned at the same time. On 09/01/20 at 07:47 AM, Administrative Nurse E stated, the care plan should include the resident's use of oxygen and the care needed for that. This resident's care plan lacked needed information related to the resident's oxygen usage and care of the oxygen equipment. On 09/01/20 at 10:15 AM, Administrative Nurse D stated, care plans should be individualized for each resident. The facility lacked a policy for care plans. The facility failed to ensure proper cleansing of this dependent resident's oxygen concentrator filter, to prevent respiratory infections.
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 50 residents with 17 sampled for review. Based on interview and record review, the facility failed to review and revise the care plans for one sampled Resident (R)15 for interventions following falls to prevent further falls for the resident. Findings included: - The signed Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the resident admitted on [DATE]. The MDS revealed the resident is rarely/never understood. Her cognition was severely impaired. She was unsteady and only able to stabilize with human assistance. She had one non-injury fall since last admission. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/28/2020, documented R15 had dementia, she was unable to recall most things. At times she recognized her husband. She was dependent on staff and family for all decision making. The Falls Care Area Assessment (CAA), dated 02/28/2020, documented R15 was unaware of her safety needs. She had impaired balance and a cognitive deficit. She had a history of [REDACTED]. She required limited assistance with walking. She had one non-injury fall since the last assessment. The care plan for falls, dated 07/22/2020, documented R15 was a high risk for falls related to confusion, had a history of [REDACTED]. She wouldl attempt to stand without staff assistance.She had pressure alarms in place on her bed and in her wheelchair. She required one-person assistance with transfers and ambulation. Staff should always ensure the resident wore non-skid footwear. Observe if the resident attempted to get up and ambulate, or transfer independently for safety. Fall Investigations revealed the following On 06/19/2020 at 02:48 PM, the resident fell while walking in her room. The facility lacked fall interventions in the care plan, after the fall. On 07/08/2020 at 08:54 PM, the resident fell from her chair to the floor. The facility lacked fall interventions in place, in the care plan, after the fall. On 06/19/2020 at 06:17 PM, the electronical medical record documented the resident stood up from her wheelchair, sat down, and was on the floor. She was assisted back into wheelchair. She was unable to state why she stood. On 07/9/2020 at 1:05 AM, the electronical medical record documented R15, at 8:54 PM, stood out of wheelchair, when she went to sit down in the wheelchair, it rolled back and landed on her buttocks. Resident shouted, well damn it, I'm on the ground. On 08/31/2020 at 07:13 AM, the resident observed in her wheelchair by the nurse station. She reached down and touched the bottom of a bedside table that was in the hall. Staff intervened and stopped resident. Then moved her wheelchair away from bedside table. On 08/27/2020 at 11:04 AM, Certified Nurse Aide (CNA) QQ, revealed R15 required assistance of one for all her cares. She had an alarm on her bed and wheelchair to alert staff if she tried to get up. On 08/31/2020 at 12:34 PM, LN I revealed after a resident would fall, staff should evaluate the resident and update the care plan to ensure new interventions are placed to avoid reoccurring falls. LN I confirmed there were no new interventions in place from the fall on 06/19/2020 or on 07/09/2020. On 09/01/2020 at 01:20 PM, Administrative Nurse D stated it was her expectation that staff should update the resident's care plans after every fall. The facility lacked a policy for review and revising of the residents' care plans. The facility failed to review and revise the resident's care plan, related to the prevention of further falls.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 17 residents sampled, including 1 resident reviewed for activities of daily living (ADLS). Based on observation, interview, and record review, the facility failed to provide appropriate oral hygiene cares for the one sampled resident, Resident (R)44. Findings included: - The Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assist of one staff for personal hygiene and had no dental issues. The ADL Care Area Assessment, dated 01/24/20, did not trigger for further review. The quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assist of two staff for personal hygiene and had no dental issues. The care plan for activities of daily living (ADLs), dated 08/25/20, instructed staff to provide mouth care (oral hygiene). Review of documentation in Point Click Care (PCC), an electronic documentation system under the Tasks tab, revealed the resident required total assistance of one to two staff for personal hygiene. On 08/26/20 at 08:51 AM, the resident sat in the dining room awaiting breakfast. She had a heavy build-up of food debris across her teeth. On 08/26/20 at 01:02 PM, the resident continued with food debris in her teeth. Observation of her shared bathroom revealed the resident did not have a toothbrush. On 08/31/20 at 10:37 AM, the resident continued with food debris in her teeth. On 08/31/20 at 07:13 AM, Certified Nurse Aides (CNA) M and Q assisted the resident up from bed for the day. No oral care was given by the staff before taking the resident out to the dining room for breakfast. The resident's shared bathroom lacked oral care supplies for the resident. On 08/31/20 at 07:13 AM, CNA M stated staff would sometimes do oral care with the resident after breakfast due to her pocketing food. Staff M stated all of the resident's oral care supplies

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) were kept in her bathroom. On 08/31/20 at 02:03 PM, CNA O stated oral care would be done with the resident before bed. The resident's toothbrush was kept in her shared bathroom and the resident did not refuse cares. On 08/31/20 at 04:00 PM, Licensed Nurse (LN) G stated, oral care should be done in the morning when a resident first gets up and then again before bed. On 09/01/20 at 12:42 PM, Administrative nurse D stated, oral care should be done at a minimum when getting up each morning and before bed. The facility lacked a policy for oral care for dependent residents. The facility failed to provide this dependent resident with appropriate oral care, as needed, when her teeth contained a build up of debris across them.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 17 residents sampled, including three residents reviewed for pressure ulcers (PU). Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services for two of the three sampled residents, including Residents (R)44, for failure to prevent the development of four stage II PUs, and R19 regarding the worsening of a PU. Findings included: - The Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for bed mobility. She was at risk for the development of pressure ulcers (PU), but had no unhealed PUs at the time of the assessment . She had a pressure reducing device for her chair and bed and was on a turning and repositioning program. She had limited range of motion (ROM) on both sides of her lower extremities. The Care Area Assessment for Pressure Ulcers, dated 01/24/20, documented the resident required total assistance with all cares and had a [DIAGNOSES REDACTED]. Staff were to turn and reposition the resident every two hours and as needed (PRN). The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for bed mobility and personal hygiene. She was at risk for the development of PU, but had no unhealed PUs at the time of the assessment . She had a pressure reducing device for her chair and bed and was on a turning and repositioning program. She had limited range of motion (ROM) on both sides of her lower extremities. The Pressure Ulcer Care Plan, dated 08/25/20, instructed staff to have the resident wear the gray multi-podus boots (boots used to help prevent the development of PUs) while she was in the wheelchair and the air boots while she was in bed. Review of the Evaluations tab in Point Click Care (PCC), an electronic documentation system, revealed Braden assessments (assessments used to determine the risk of skin breakdown) which revealed assessments completed on 12/11/19, 03/11/20, and 04/12/20, which placed the resident at a high risk for skin breakdown and an assessment completed on 08/27/20, which placed the resident at a severe risk for skin breakdown. Review of Skin and Wound Evaluation in PCC included the following documentation: On 8/28/20, Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed) PU to the second toe of the right foot, measured 1.3 cm (centimeters) in length (L) by 0.8 cm in width and acquired in-house. Documentation lacked description of the wound bed, exudate (drainage), odor, and periwound (surrounding wound tissue). On 09/01/20, documentation revealed the Stage II PU to the second toe of the right foot, which measured 1.86 cm by 1.29 cm. The form also identified another new Stage II PU to the third toe of the right foot, which measured 0.9 cm by 0.7 cm, and developed in-house. The area had no exudate or odor and the periwound was discolored black/blue. Documentation lacked description of the wound bed. On 09/01/20, documentation revealed the Stage II PU to the third toe of the right foot, measured 0.96 cm by 0.64 cm . The form identified another new area, Stage II PU to the fourth toe of the right foot, which measured 1.2 cm by 0.8 cm, and developed in-house. The wound had no exudate or odor. The periwound was blanchable (when a patient's skin loses redness with pressure). Documentation lacked description of the wound bed. On 09/01/20 documentation revealed the Stage II PU to the fourth toe of the right foot, measured 0.79 cm by 0.59 cm. Stage II PU to the fifth toe of the right foot, measured 0.9 cm by 0.4 cm, acquired in-house. No exudate or odor. Periwound discolored black/blue. Documentation lacked description of the wound bed. On 09/01/20 documentation revealed the Stage II PU to the fifth toe of the right foot, measured 0.99 X 0.54 cm . Treatment orders, dated 08/27/20, instructed staff to cleanse the areas to the toes on the right foot with normal saline (NS) and apply a generous amount of [MEDICATION NAME] (antiseptic)., Leave open to air twice daily (BID) and every one hour, as needed (PRN), for blisters. Staff were also to administer Proheal (medical food developed for the dietary management of wounds and conditions requiring supplemental protein) 30 ml (millimeters), by mouth (po), BID; Vitamin C 500 mg (milligrams), po every day (QD); Multivitamin po, QD; and Zinc 220 mg, po QD. On 08/27/20 at 11:25 AM, the resident rested in bed bare footed. The resident had four open areas to the tops of her 2nd, 3rd, 4th, and 5th toes of her right foot. The open areas were dry and dark red. Physician SS came into the room to see the resident and stated, The areas are certainly pressure . On 08/31/20 at 07:10 AM, the resident rested in bed on the air mattress. The resident had on bunny boots (pillow cushioning boot with toes open) to her bilateral feet. The resident's right foot was partially out of the boot with the open areas of her toes/feet pushing up against the foot area of the boot. On 08/31/20 at 02:57 PM, Licensed Nurse (LN) G entered the resident's room to do a treatment for [REDACTED]. Staff G washed her hands with soap and water and applied gloves, cleaned the resident's wounds on the right foot with normal saline and patted dry with a guaze pad. Staff G then removed her gloves, washed her hands with soap and water, put on new gloves and then applied [MEDICATION NAME] to all four open areas, as ordered. On 08/31/20 at 04:30 PM, the resident rested in bed. The blankets covering the resident rested directly on the open areas of her toes. On 09/01/20 at 10:54 AM, Administrative Staff D, entered the resident's room to measure the areas on the resident's toes. The resident's right foot had come partially out of the boot with the open areas of her feet pushing up against the foot area of the boot . On 09/01/20 at 02:59 PM, the resident rested in bed. Her right foot was partially out of the boot with the open areas of her feet up against the foot area of the boot. On 08/31/20 at 007:13 AM, Certified Nurse Aide (CNA) M stated, staff attempted to keep the resident's toes open to air due to the pressure ulcers (PU) on her toes. The resident curled her toes so the boot did not stay in place on her foot and her toes would come to rest directly against the boot. On 08/31/20 at 02:03 PM, CNA O stated, the resident had PUs on her toes, but staff did not know how they occurred. She wore bunny boots while in bed with socks and the bed linens/blanket would rest directly on her toes. On 08/31/20 at 04:30 PM, CNA P stated she had been instructed to not put the resident's bunny boots or socks on her anymore while she was in bed. CNA P confirmed the blanket would rest directly on the open areas of the resident's toes. On 08/31/20 at 04:00 PM, LN G stated, the resident currently had four new PUs to the top sides of her toes. Staff were unsure of what caused the PUs to develop. On 09/01/20 at 10:15 AM, Administrative Nurse D stated, the resident had four new stage II PUs to her toes which developed on Thursday. Staff D stated the reason for the development of the PUs was due to the resident curling her toes when her socks were on. The intervention was to remove the resident's socks when she was in bed at night and the air boots were removed from the resident's room. Staff would continue to use the bunny boots while the resident was in bed. The facility planned to put a cradle (wire lifted device to keep bed linens/pressure off of the resident) on the resident's bed to prevent the blankets from touching the resident's toes, but therapy had not been notified about this yet . The facility policy for Skin Care Guidelines, dated July 2018, included: The facility will have a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care in disruption of skin integrity. The facility failed to ensure appropriate services to prevent the development of four stage II PUs on the tops of this dependent resident's toes. - The signed Physician order [REDACTED]. The Significant Change Minimum Data Set, dated dated [DATE], documented R19's cognitive status as moderately impaired. She was independent with bed mobility and transfer, had occasional pain, and did not have pressure ulcers. The Pressure Ulcer/Injury Care Area Assessment, completed 06/29/2020, documented R19 was at risk for pressure injury. The pressure ulcer care plan, revised 08/26/2020, instructed staff to perform weekly pressure ulcer monitoring and measurement. A physician's orders [REDACTED]. dressing was in place, every day. The Treatment Administration Record, (TAR) dated 08/01/2020 to 08/31/2020, lacked documentation of treatment to R19's coccyx on 08/26/2020. The TAR lacked documentation regarding monitoring of the coccyx dressing. The Progress Notes documented staff monitored the coccyx dressing on 08/08/2020 and on 08/15/2020. (R)19's Skin & Wound Evaluation dated 08/30/2020, documented a dressing was in place however, lacked the location of the wound. On 08/27/2020 at 03:21 PM, Licensed Nurse (LN) H uncovered R19 to check on the coccyx pressure ulcer. The coccyx pressure ulcer lacked a dressing. At the surveyor's request, LN H obtained measurements. The pressure ulcer measured 3.5 by 3.0 centimeters (cm). The surrounding tissue was without irritation or redness. On 08/31/2020 at 01:14 PM, LN G removed R19's coccyx dressing, dated 08/27/2020. Staff measured the redness around the open pressure ulcer and the redness measured 5.4 cm long by 8.0 cm wide. The redness above the wound remained completely red when LN G pressed on the surrounding tissue. Administrative Nurse D observed the area at this time. On 08/31/2020 at 04:40 PM, Administrative Nurse D verified staff lacked monitoring of the pressure ulcer since 08/01/2020, and

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) reported staff should monitor the resident's skin ulcer weekly. Furthermore, the physician's orders [REDACTED]. The Treatment Administration Record, dated 08/01/2020 to 08/31/2020, documented staff provided treatment to R19's left elbow pressure ulcer up through and including 08/26/2020. On 08/27/2020 at 03:35 PM, R19's left elbow's dressing dated 08/26/2020. LN H stated the pressure ulcer was healed and the dressing was a protective barrier. On 08/31/2020 at 01:20 PM, upon request, LN G removed the dressing on R19's left elbow, dated 08/26/2020 (a total of four days later). LN G, and Administrative D, verified they thought the area was Healed. LN G measured the left elbow pressure ulcer as 0.9 cm by 1.0 cm wide. On 08/31/2020 at 04:40 PM Administrative Nurse D verified the resident's left elbow pressure ulcer had not been measured since 08/21/2020. She verified staff failed to monitor R19's pressure ulcers weekly, for improvement or worsening of the pressure ulcers. The facility's policy titled, Skin Care Guideline, dated July 2018, instructed staff to assess pressure ulcers weekly. The facility failed to appropriately assess and treat the resident's pressure ulcers on her coccyx and left elbow, to promote healing, and prevent further pressure ulcer development.
F 0688 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 17 residents sampled, including three residents reviewed for restorative services. Based on observation, interview, and record review, the facility failed to provide restorative services for three sampled Residents (R)44, R 32 and R 6, to maintain or prevent decline in range of motion (ROM) ability. The facility failed to provide R44 with the planned restorative services for at least 10 months. R44's arms became tighter with contractures, with increased difficulty to dress, and the need for increased muscle relaxant medication from the physician. Findings included: - The Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for dressing and total assistance of one staff for personal hygiene. She had no impairment in functional range of motion (ROM) of the upper extremities and bilateral impairment in ROM of the lower extremities. She received passive range of motion (PROM) one day of the assessment period. The Care Area Assessment for Activities of Daily Living (ADL), dated 01/24/20, did not trigger for further review. The Quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed the resident had severe cognitive impairment. She required total assistance of two staff for dressing and personal hygiene. She had no impairment in functional range of motion (ROM) of the upper extremities and bilateral impairment in ROM of the lower extremities. She did not receive any restorative services during the assessment period. The Restorative Care Plan, dated 12/16/19 and revised 08/25/20, instructed the staff to perform PROM. review of the resident's medical record revealed [REDACTED]. The facility lacked documentation evidence of restorative services completed. Review of the resident's medical record in Point Click Care (PCC), an electronic documentation system, under the Progress Notes tab, revealed the following nursing documentation, dated 08/19/20: The resident was found to have redness to her axillaries (arm pits) with a foul odor, redness, and moisture. Staff were unable to fully assess due to the resident's rigidity and limited ROM. Review of the resident's medical record in PCC under the Progress Notes tab, revealed the following nursing documentation, dated 08/20/20: Staff observed the resident as appearing to be tensed up and rigid mostly in her upper extremities. Staff reported her rigidity was causing difficulty with all activities of daily living (ADLS), especially dressing and undressing. It was also difficult for staff to get her blood pressure due to the resident being tense. Nurse updated the daughter regarding the resident's status and the daughter would like to have the resident evaluated for therapy. Message sent to the resident's physician inquiring about further orders. Currently awaiting response from the physician. Review of the resident's medical record chart, behind the physician's orders [REDACTED]. Staff have difficulty dressing her and obtaining her blood pressure (BP). She was receiving [MEDICATION NAME] (a muscle relaxer medication) 4 mg (milligrams) twice daily (BID), as needed (PRN), but this does not seem to help. The physician responded on 08/21/20 with a new order for [MEDICATION NAME] 2 mg (milligrams) three times a day (TID), for rigidity and tight muscles. Review of the resident's medical record in PCC under the Progress Notes tab, revealed the following nursing documentation, dated 08/22/20: Contacted on call APRN (Advanced Practice Registered Nurse) and requested an order for [REDACTED]. APRN responded with a new order for [MEDICATION NAME] 150 mg, one time. On 08/26/20 at 08:51 AM, the resident sat in her geri-chair (high back specialized wheelchair). The resident's bilateral shoulders pulled up with her elbows and wrists contracted (abnormal permanent fixation of a joint). On 08/27/20 at 11:20 AM, Certified Nurse Aide (CNA) TT and CNA N positioned the resident in the bed. Staff have a difficult time straightening the resident's shirt due to her arms being held tightly against her torso and her elbows being difficult to open. On 08/31/20 at 07:13 AM, CNA M and Q dressed the resident for the day. Staff explained they have a difficult time getting the resident's shirt on due to her upper extremities being tight. On 08/31/20 at 09:53 AM, CNA M and Q lay the resident down following breakfast. Staff have a difficult time situating the resident's shirt due to her contracted upper extremities. On 08/31/20 at 07:13 AM, CNA M stated, the facility does not currently have a restorative aide. No restorative was being done with the residents. The resident had contractures in her shoulders and she had an odor in her arm pits. Staff were not able to get her arms moved out far enough to clean well in the resident's arm pits. The resident did not refuse cares. On 08/31/20 at 09:53 AM, CNA N stated the resident had contractures to her arms for a long time, however, her arms at the elbows have become much stiffer than they were before. Staff have a difficult time getting her shirt on and off and the resident had reddened areas in the crease of her elbow. The resident had become stiffer due to not receiving restorative care for at least 10 months, according to staff N. On 08/31/20 at 02:03 PM, CNA O stated, the resident has contractures which make it difficult for staff to get her shirts on and off. It takes two staff to get her dressed because of the contractures. Lately, she has been keeping her arms tucked in more tightly. Currently, no staff are doing restorative care. On 08/31/20 at 04:30 PM, CNA P stated, the resident was a lot stiffer lately in her arms and shoulders. It's difficult to get her arm pits and elbow areas clean. The resident did not refuse cares. On 09/01/20 at 07:30 AM, CNA Q stated, the resident's arms are tight which makes it difficult to get them pulled out far enough to get her shirt on. CNA Q stated she does not do ROM with the resident. On 09/01/20 at 02:55 PM, CNA MM stated, the resident was stiff and it was hard to get her clothes on and off. The resident did not refuse cares. On 08/31/20 at 04:00 PM, Licensed Nurse (LN) G stated she was not sure if restorative care was being done with residents or not. On 09/01/20 at 07:47 AM, Administrative Nurse E stated, currently there was no restorative taking place in the facility. Some residents have programs in place, including this resident, but nobody was working as a restorative aide at this time. Staff E was unsure of an exact date that restorative services were completed. On 09/01/20 at 01:53 PM, therapy staff NN stated, the resident received occupational therapy from 04/27/20 until 05/23/20 for bed and wheelchair positioning. When she came off of therapy, she was put onto a restorative program which was to include hip abduction, hip and knee flexion, ankle rotation, toe flexion and extension, hamstring stretch, finger and wrist flexion and extension, thumb flexion and extension, elbow flexion and extension, shoulder flexion and extension, neck rotation, and neck flexion. Staff were to complete these exercises at a minimum of three times a week by the restorative aide. On 09/01/20 at 10:15 AM, Administrative Nurse D stated, she did not believe the resident was becoming stiffer, but some of the staff thought she was getting stiffer. The facility had not had anybody doing restorative for at least 10 months. A message was left with the physician SS on 09/02/20, with no return call to date. The facility policy for Restorative Guidelines, dated 2019, included: Restorative services are used to assist the resident in reaching her highest level and then maintain the function. Measurable objectives and interventions must be documented in the care plan. The facility failed to provide restorative services as planned for at least 10 months for this dependent resident, causing her to decline in her range of motion ability, with increase difficulty in dressing, and the need for an increase in her muscle relaxant medication ordered from the physician. - The signed Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], revealed R32 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she had intact cognition. She had occasional mild pain. She used opioid (narcotic pain medication) four on the seven days on the look back period. The Pain Care Area Assessment, dated 12/19/12 did not trigger. The Quarterly MDS, dated [DATE], documented the resident had occasional mild pain and used opioid medication four days of the seven day look back period. The care plan, dated 08/19/2020, instructed staff that R32 was in the restorative nursing program for active range of motion to restore or maintain her level of function in both shoulders. Review of restorative electronic medical records revealed staff administered services for seven of the 31 days. On

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F 0688 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 4) 08/26/2020 at 12:59 PM, the resident reported she had occasional pain in her shoulder and should have received exercises to help with the pain. It really gets stiff at times. I have not had anyone work on my shoulder for a long time. On 08/27/2020 at 08:06 AM, direct care staff QQ stated the resident does have stiffness in her shoulder. She verified staff failed to provide the resident exercise or restorative. On 09/01/2020 at 07:47 AM, Administrative Nurse E, stated there was no restorative services for the residents in the facility. There have been programs in place, but nobody is carrying out the plans currently. The restorative aide was not doing restorative as she was needed to work the floor as direct care staff. Administrative Nurse D are aware that there is no restorative services. On 09/01/2020 at 10:15 AM, Administrative Nurse D, stated the restorative aide is working the floor, instead of providing restorative services. The policy Restorative Guideline dated 2020, instructed restorative services was to assist the resident in reaching his/her highest level, and then maintain that function. Measurable, objectives and interventions must be documented in the care plan. The facility failed to provide appropriate restorative services to increase or maintain range of motion, for this resident who had shoulder pain, to prevent a decline in range of motion ability. - The signed Physician order [REDACTED]. functions, including blood pressure, heart rate, bladder function, and digestion), muscle contracture, muscle wasting, and generalized [MEDICAL CONDITION] (swelling resulting from an excessive accumulation of fluid in the body tissues). The annual Minimum Data Set, dated dated [DATE], documented (R)6 was cognitively intact and had functional limitation in all his extremities. He required staff to feed, dress, toilet, transfer, and bathe him, as well as to perform his personal hygiene and move him in bed . The ADL (Activity of Daily Living) Functional /Rehabilitation Potential Care Area Assessment (CAA), dated 06/05/2020, revealed (R)6 was quadriplegic and required total dependence of staff for all his cares. The current Care Plan instructed staff to perform Passive Range of Motion (PROM (amount of motion at a given joint when the joint is moved by an external force) for his Restorative program. The care plan lacked guidance for the resident's individual range of motion program. A Progress Note, located in the electronic medical record (EMR), dated 04/22/2019, documented a Passive Range of Motion Program that required staff to exercise his arms and legs for 15 minutes a day, for three to six days, each week. On 08/31/2020 at 07:58 AM, Certified Nurse Aide (CNA)N reported the facility lacked a restorative aide since October 2019 (a total of 10 months), related to the restorative aide was Pulled to work the floor as a CNA. On 09/01/2020 at 07:47 AM, Administrative Nurse E reported the facility lacked restorative services for the residents of the facility. There were programs in place previously, however nobody (staff) carried out the restorative programs. The restorative aide was unable to perform restorative as restorative staff were Needed to work on the floor as a CNA. On 09/01/2020 at 10:15 AM, Administrative Nurse D verified the facility failed to have residents participate in a restorative program. On 09/01/2020 at 01:53 PM Consultant NN explained that (R)6 required staff to perform exercises to his hips, knees, ankles, toes, shoulders, elbows, wrists, fingers, thumbs, and neck. (R)6 was unable to feel ort move himself due to his spinal cord injury, he was at risk for contractures (abnormal permanent fixation of a joint) and required the exercises to help with his blood flow as well as to maintain his skin integrity. The facility policy for Restorative Guidelines, dated 2019, included: Restorative services are used to assist the resident in reaching her highest level and then maintain the function. Measurable objectives and interventions must be documented in the care plan. The facility failed to provide appropriate restorative treatment and services to maintain range of motion, for this dependent resident who had no movement to his extremities, to prevent further contractures.
F 0689 **Level of harm** - 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 50 residents with 17 residents sampled, including five residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to implement care planned interventions to prevent falls. Resident (R) 152, who had severe cognitive impairment, fell and experienced a spiral fractured right arm. Findings included: - The signed undated Physician order [REDACTED]. affecting older adults. It's primary feature of cognitive decline, which could lead to hallucinations (seeing things while awake that appear to be real, but the mind created), and delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue as well as varied attention and alertness)), and repeated falls. The Significant Change Minimum Data Set (MDS), dated [DATE], documented the resident admitted on [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severely impaired cognition. She required limited one-person physical assistance when ambulating in the corridor, in the room, transfers, toileting, and with locomotion. She used a walker to ambulate. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/25/20, documented she admitted with [DIAGNOSES REDACTED] and [MEDICAL CONDITION]. She was able to carry on a day to day conversation and could make her needs known. She could recognize the staff. The Activity of Daily Living Functional/Rehabilitation CAA, dated 02/25/20, did not trigger for further review. The Falls CAA, dated 02/25/20, documented R152 had a history of [REDACTED]. She required limited assistance for transfers and mobility. Her cognition was not well and she could not remember to use her call light. Staff administered medications to the resident to help keep her calm and keep her hallucinations and delusions under control. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of two, indicating severely impaired cognition. She had continuous inattention and disorganized thinking. She was independent with transfers, walking, locomotion and required supervision with toileting. She used a walker and had one injury fall since the last assessment. The revised Activities of Daily Living (ADL) Care Plan, dated 06/03/20, instructed staff that R152 should ambulate with a rolling walker and required standby/limited assistance for safety. The revised Falls Care Plan, dated 06/03/20, instructed staff to keep the resident's room free of clutter and to ensure her path to the bathroom remained clear. Review of the Electrical Medical Record, on 07/18/20, documented R152 fell in her room. The resident was in a prone position (lying flat) on the left-hand side of the bed. Her right arm was bent at the elbow with her hand by her face. She was wearing her tennis shoes. She was unable to tell staff how she fell and said she hurt all over, but mostly on her right arm. She reported it felt like she broke it. There was a hematoma (blood filled bruise) on her left temple and her right arm had a large bulge approximately five inches from her shoulder. Her right arm was flaccid (limp, soft and flabby). There was obvious weakness on her right grip over the left grip. On 07/18/20 at 06:30 PM, Post Fall Review documentation added there were several shoes noted on the floor between where the resident was found and the recliner where she usually sat. On 07/19/20 at 01:51 PM, the Electronic Medical Records revealed the resident as hospitalized for [REDACTED]. On 08/31/20 at 12:34 PM, Licensed Nurse (LN) I, reported R152 required assistance of one staff with all cares. She was very unstable, and staff would go in immediately after supper to assist her as she would try to put herself in the bed. She had a walker, however the resident would not use the walker in her room even with signs put up and frequent reminders informing her to call staff for assistance. Staff would change her shoes from slippers to tennis shoes and leave her shoes by her chair. Staff should put her shoes in her closet to keep her room free of clutter free, as planned to prevent further falls. On 09/01/2020 at 02:10 PM, CNA R reported she found the resident when she fell and broke her arm. The resident was in her room alone and it was an unwitnessed fall. The resident's shoes were by her chair at the time. She did not pick them up as this was where staff would routinely leave them to switch the shoes back and forth. The resident's room should be kept clean and clutter free . On 09/01/20 at 04:14 PM, Administrative Nurse D stated at the time of the resident's fall with the fractured arm, the room should have been free of clutter. The facility undated Fall policy instructed that the purpose was to establish a process that identified risk and established interventions to mitigate (make less severe, serious, or painful) the occurrence of falls. The facility failed to implement a planned intervention to keep the resident's room clutter free to prevent further falls for the resident, who fell with shoes by the recliner and she experienced a spiral [MEDICAL CONDITION].
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 17 residents sampled, including five residents reviewed for respiratory issues. Based on interview, record review, and observation, the facility failed to ensure proper cleaning of respiratory equipment for the five sampled residents, including four of the five Residents (R)11, R35, R19, and R27 regarding dirty oxygen concentrator filters; and two of the five residents, R32 and R19 regarding tubing not being replaced timely on the oxygen concentrators. 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 intact cognition. She

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) required extensive assistance of two staff for bed mobility and used oxygen. The Care Area Assessment, dated 04/01/20, did not mention the resident's oxygen use. The Oxygen Care Plan, dated 07/09/20, instructed staff the resident required continuous oxygen therapy for [MEDICAL CONDITION]. Review of the resident's medical record in Point Click Care (PCC), an electronic documentation system, under the Orders tab, revealed a physician order [REDACTED]. On 08/27/20 at 01:37 PM and on 08/31/20 at 08:16 AM, the resident's filter on the back of her oxygen concentrator had a build-up of heavy dust and debris. The resident was currently using the oxygen at the times. On 08/31/20 at 09:00 AM, Certified Nurse Aide (CNA) M stated, staff changed the residents' oxygen tubing on Sunday nights. Staff M was unsure if the staff cleaned the filters to the concentrators at that time. On 08/31/20 at 04:00 PM, Licensed Nurse (LN) G stated, the night nurse would change the oxygen tubing weekly. Staff G did not know about the cleaning of the oxygen concentrator filters. On 09/01/20 at 11:07 AM, Administrative Nurse D stated, the oxygen tubing needed to be changed weekly and the concentrator filters needed to be cleaned at the same time. The facility policy for Departmental (Respiratory Therapy) Prevention of Infection, revised November 2011, included: Wash the filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. The facility failed to ensure proper cleansing of the filter for the oxygen concentrator for this dependent resident, with respiratory illness, to prevent respiratory infections. - The Physicians Order Sheet (POS), dated 08/19/20, documented Resident (R) 27 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 8, indicating she had moderately impaired cognition. She required oxygen usage, total assist of two staff for personal hygiene and had limited range of motion (ROM) on one side of her upper extremities. The Care Area Assessment, dated 07/17/20, did not mention oxygen usage. The Care Plan, dated 07/29/20, lacked staff instruction regarding oxygen use or proper cleaning of the concentrator machine. Review of the resident's medical record in Point Click Care (PCC), an electronic documentation system, under the Orders tab revealed a physician order [REDACTED]. The oxygen concentrator filter contained a heavy build-up of dust and debris. On 08/31/20 at 09:00 AM, Certified Nurse Aide (CNA) M was unsure if the filters to the oxygen concentrators were cleaned at on Sunday nights when staff changed the tubing. On 08/31/20 at 04:00 PM, Licensed Nurse (LN) G stated, the night nurse would change the oxygen tubing weekly. Staff G did not know about the cleaning of the oxygen concentrator filters. On 09/01/20 at 11:07 AM, Administrative Nurse D stated, the oxygen tubing needed to be changed weekly and the concentrator filters needed to be cleaned at the same time. The facility policy for Departmental (Respiratory Therapy) Prevention of Infection, revised November 2011, included: Wash the filters from the oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. The facility failed to ensure proper cleansing of this dependent resident's oxygen concentrator filter, to prevent respiratory infections. - The Physician order [REDACTED]. The significant change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 8, indicating she had moderately impaired cognition. She required oxygen usage and the total assistance of one staff for personal hygiene. The Care Area Assessment (CAA), dated 04/08/20, lacked documentation of oxygen use. The quarterly MDS, dated [DATE], documented the resident had a BIMS score of 9, indicating she had moderately impaired cognition. She required oxygen usage and extensive assistance of one staff for personal hygiene. The [MEDICAL CONDITION] Care Plan, dated 08/19/20, instructed staff that the resident used oxygen continuously. Review of the resident's POS, dated 08/01/20, documented staff were to cleanse the oxygen concentrator's air filter every evening shift on Sundays, ordered 02/05/20. On 08/27/20 at 08:23 AM, the resident sat in the dining room with her oxygen on. The filter of the oxygen concentrator had a heavy build-up of dust and debris. On 08/31/20 at 07:12 AM, the resident rested in bed with the oxygen on. The filter of the oxygen concentrator had a heavy build-up of dust and debris. On 08/31/20 at 09:00 AM, Certified Nurse Aide (CNA) M stated, staff changed the oxygen tubing on Sunday nights. Staff M was unsure if the filters to the concentrators were cleaned at that time. On 08/31/20 at 04:00 PM, Licensed Nurse (LN) G did not know about the cleaning of the oxygen concentrator filters. On 09/01/20 at 11:07 AM, Administrative Nurse D stated, the oxygen concentrator filters needed to be cleaned at the same time the staff changed the oxygen tubing on Sunday nights. The facility policy for Departmental (Respiratory Therapy) Prevention of Infection, revised November 2011, included: Wash the filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. The facility failed to ensure proper cleansing of this dependent resident's oxygen concentrator filter, to prevent respiratory infections. - The signed Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], revealed R32 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she had intact cognition. She was dependent on oxygen usage. The Quarterly MDS, dated [DATE], documented the resident required oxygen. The care plan, dated 08/19/2020, instructed staff to remind the resident not to push herself beyond her endurance. Oxygen setting was by nasal cannula (a tubing device used to administer oxygen through the nose) at two liters at night and when needed. The signed physician's orders [REDACTED]. On 08/27/2020 at 08:12 AM, observation of the resident's oxygen tubing and water cannister, revealed a date of 07/17/2020 (A total of 39 days). On 08/31/2020 at 09:41 AM, observation of the resident's oxygen tubing and water cannister, dated 07/19/2020. (A total of 43 days). On 08/31/2020 at 09:45 AM, LN I reported the night shift staff should change the resident's tubing and water cannister every seven days, on Sundays. On 09/01/2020 at 11:07 AM, Administrative Nurse D confirmed the expectation was the resident's oxygen and water canister should be changed every Sunday. The facility's policy for Departmental (Respiratory Therapy) Prevention of Infection, revised 2011, instructed staff to change the oxygen tubing every seven days or as needed. The facility failed to provide adequate change in oxygen tubing and water canister for this resident that required oxygen, for 43 days, to prevent respiratory infections. - The signed Physician order [REDACTED]. The significant change Minimum Data Set, dated dated [DATE], documented R19's cognitive status as moderately impaired. She was independent with bed mobility and transfer and used oxygen. The current respiratory care plan lacked instructions to the staff to clean the resident's oxygen concentrator filter or to change the oxygen tubing. On 08/26/20 at 03:40 PM and on 08/31/20 at 04:55 PM, R19's oxygen tubing lacked any date of when it was changed last. The oxygen concentrator's filter contained a layer of visible gray colored accumulation (dust/debris) over the outer edge. On 09/01/20 at 11:07 AM, Administrative Nurse D stated the tubing on the oxygen concentrators needed to be changed weekly and dated. The filters on the oxygen concentrators should be cleaned at the same time. The facility policy for Departmental (Respiratory Therapy) Prevention of Infection, revised November 2011, included: Change the oxygen tubing every seven days or as needed. Wash the filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry. The facility failed to maintain the resident's respiratory equipment to professional standards to reduce risk of respiratory infections for this resident.
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 interview and record review, the facility failed to provide individualized in-services, based on evaluation outcomes for three of three Certified Nurse Aides reviewed, to ensure adequate cares provided to the residents. Findings included: - The facility provided three Certified Nurse Aides (CNA) personnel files that worked at the facility for over a year. Review of the three CNA personnel files revealed the three CNA's lacked an annual evaluation, to determine their individualized needs for in-services education. On 09/01/2020 at 02:10 PM, Administrative Nurse D confirmed the failure to complete any evaluations in the past year for any/all Certified Nurse Aides. The facility lacked a policy regarding annual evaluations and individualized staff in-services. The facility failed to ensure provision of the required training, based on the evaluations of the direct care staff, employed by the facility, to ensure adequate cares provided to the residents.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 17 sampled for review, including six residents reviewed for unnecessary medications. Based on, interview and record review, the pharmacy failed to identify the irregularity of the facility failure to monitor pulses which were out of parameters for Resident (R) 49, who received antihypertensive medications. In addition, the facility failed to act upon recommendations of the consultant pharmacist by failing to consistently send pharmacy recommendations to the residents' physicians for R11, R31, R35, and R6. Findings included: - The signed Physician

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F 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) order [REDACTED]. The [MEDICAL CONDITION] plan, dated 08/21/2020, instructed staff to give medication as ordered. The POS, dated and signed 7/14/2020, documented the following orders: 1.) [MEDICATION NAME] (a medication used to treat high blood pressure), 10 milligrams (mg) daily [MEDICAL CONDITION] to notify the physician if the resident's pulse was over 100 or less than 60, ordered on [DATE]. 2.) [MEDICATION NAME] (a medication used to treat high blood pressure), 50mg/25mg daily [MEDICAL CONDITION] to notify the physician if the resident's pulse was over 100 or less than 60, ordered on [DATE]. 3.) [MEDICATION NAME] (a medication that dilates (widens) blood vessels and improves blood flow), 5mg, 2 tablets at bedtime daily for HTN, and to notify the physician if the resident's pulse was over 100 or less than 60, ordered 05/05/2020. Review of the electronic Medication Administration Record, [REDACTED].) [MEDICATION NAME] 5mg 2 tabs at bedtime, staff administered the resident's medication on eight of 92 occasions when the pulse was less than 60. 2.) [MEDICATION NAME]-[MEDICATION NAME] 50-25 daily, staff administered the resident's medication on 12 of 92 occasions when the pulse was less than 60. 3.) [MEDICATION NAME] 10 mg daily, staff administered the resident's medication on 12 of 92 occasions when the pulse was less than 60. The Pharmacy Review Recommendations/Irregularities, dated 6/24/2020 at 10:31 AM, 07/22/2020 at 02:54 PM, and on 08/25/2020 at 02:38 PM, all revealed no medication irregularity mentioned. On 08/31/2020 at 12:34 PM, Licensed Nurse (LN) I confirmed staff administered the medications when the resident's documented pulses were out of the physician ordered parameters, and stated staff should not have administered the medications due to the pulses being below 60. On 09/01/2020 at 12:14 PM, Pharmacy Consultant GG confirmed he conducted the pharmacy reviews, and reported he did not find the above irregularities during his medication reviews. On 09/01/2020 at 01:10 PM, Administrative Nurse D reported the expectation was that the pharmacy reviews should identify any medication irregularities. The facility lacked a policy for the pharmacy to review medication administration for irregularities. The Consultant Pharmacist failed to identify the antihypertensive medication monitoring irregularities, when the facility failed to identify monitoring pulses, out of physician orders [REDACTED]. - The Physician order [REDACTED]. She had orders for Polyethylene (medication to ease passage of stools), 17 (gm) grams, by mouth (po), for constipation, ordered 07/06/20 and [MEDICATION NAME] (iron), 325 milligrams (mg), po, twice daily (BID), for [MEDICAL CONDITION], ordered 10/24/19. The annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. She had no constipation. Review of the resident's chart revealed monthly consultant pharmacy reviews with recommendations, which included: On 04/23/20, consultant staff GG wrote a recommendation to decrease [MEDICATION NAME] 325 mg, po, BID, to 325 mg, po, every day (QD). The facility failed to receive a response back from the resident's physician regarding the recommendation. On 05/27/20, consultant staff GG wrote a recommendation to mix Polyethylene, 17 gm, in four to six ounces of water, as needed (PRN), to administer. The facility failed to receive a response from the resident's physician regarding the recommendation back from the physician. On 09/01/20 at 12:14 PM, consultant staff GG stated, it was the expectation the facility would send the recommendations out to each resident's physician for review. On 09/01/20 at 08:38 AM, Administrative Nurse D stated, she was responsible for sending the pharmacy consultant recommendations to the physicians for review. However, some of the recommendations were sent out and some were not sent. Staff D was unable to give an explanation for why some of the recommendations were not sent. The facility policy for Medication Regimen Review, effective 12/01/07, included: The facility should encourage the physician/Prescriber receiving the medication regimen review (MRR) and the Director of Nursing to act upon the recommendations contained in the MRR. The facility failed to act upon the pharmacy recommendations for this resident, related to no follow-up with the physician. - The Physician order [REDACTED]. The resident had a physician order [REDACTED]. The facility failed to follow up on this recommendation since they failed to receive a response from the resident's physician regarding the recommendation. On 09/01/20 at 12:14 PM, consultant staff GG stated, it was the expectation the facility would send the recommendations out to each resident's physician for review. On 09/01/20 at 08:38 AM, Administrative Nurse D stated, she was responsible for sending the pharmacy consultant recommendations to the physicians for review. Staff D stated some recommendations were sent out to the physician and some were not sent. Staff D was unable to give an explanation for why some of the recommendations were not sent to the physician for review. The facility policy for Medication Regimen Review, effective 12/01/07, included: The facility should encourage the physician/Prescriber receiving the medication regimen review (MRR) and the Director of Nursing to act upon the recommendations contained in the MRR. The facility failed to act upon the pharmacy recommendations and ensure physician follow up, for this resident. - The Physician order [REDACTED]. The resident had physician orders [REDACTED]. The [MEDICAL CONDITION] Drug Use Care Area Assessment (CAA), dated 04/08/20, documented the resident had a significant history of depression. The Mood Care Plan, dated 08/19/20, instructed staff the resident took antidepressant medications and instructed the staff to monitor the resident for depressive behaviors. Review of the resident's chart revealed consultant pharmacy recommendation, which included: On 01/22/20, pharmacy consultant GG recommended a gradual dose reduction (GDR) on [MEDICATION NAME]. The facility did not receive a response regarding the GDR until 03/03/20. On 08/25/20, pharmacy consultant GG recommended a decrease of [MEDICATION NAME] 325 mg, po, BID, to [MEDICATION NAME] 325 mg, po, every day. The facility lacked any records of this recommendation from the pharmacist as being followed up on. On 09/01/20 at 12:14 PM, consultant staff GG stated, it was the expectation the facility would send the recommendations out to each resident's physician for review. On 09/01/20 at 08:38 AM, Administrative Nurse D stated, she was responsible for sending the pharmacy consultant recommendations to the physicians for review. Staff D stated some of the recommendations were sent out and some were not sent. Staff D was unable to give an explanation as to why some of the recommendations were not sent to the physicians. The facility policy for Medication Regimen Review, effective 12/01/07, included: The facility should encourage the physician/Prescriber receiving the medication regimen review (MRR) and the Director of Nursing to act upon the recommendations contained in the MRR. The facility failed to act upon the pharmacy recommendations for this resident, to ensure follow up by the physician on the recommendations. - The signed Physician order [REDACTED]. functions, including blood pressure, heart rate, bladder function, and digestion), muscle contracture (a tightening or shortening of muscles causing joint stiffness), muscle wasting (muscle weakening and shrinking), and generalized [MEDICAL CONDITION] (swelling resulting from an excessive accumulation of fluid in the body tissues). The annual Minimum Data Set, dated dated [DATE], documented R6 was cognitively intact and had functional limitation in all his extremities. He required staff total assistance for all activities of daily living needs and received antidepressant medications daily. The [MEDICAL CONDITION] Drug Use care area assessment, signed 6/20/2020, stated the resident was a quad and has severe anxiety and depression because he was unable to do anything for himself. Staff were to administer medications per physician order [REDACTED]. The antidepressant care plan, dated 11/26/19, identified the resident received three antidepressants (a class of medications used to treat mood disorders and relieve symptoms of depression), including [MEDICATION NAME]. A Pharmacy Recommendation, signed on 5/1/2020, documented a recommended dosage reduction for R6's [MEDICATION NAME]. The Pharmacy Progress Notes, in the electronic medical record, documented pharmacy recommendations were made for R6 on 03/27/19, 08/28/19, 09/25/19, 10/30/19, 12/28/19, 01/22/2020, 02/19/2020, 03/26/2020, 04/22/2020, 05/27/2020, 07/22/2020, and on 08/25/2020. On 08/31/20 at 02:27 PM, Administrative Nurse D verified from March 2019 to August 2020, the facility lacked any pharmacy recommendations for R6, other than from 01/22/2020, 03/26/2020, and 05/27/2020. On 09/01/2020 at 10:40 AM, Administrative Nurse D stated that the pharmacy recommendations for the most part had not been sent off to the physicians, that some were sent to the physicians and some were not. For the ones that were not sent, the facility failed to do anything with them. On 09/01/2020 at 12:14 PM, Pharmacist (GG) verified the pharmacy recommendations should be sent to the physician for review. Review of the pharmacist provided recommendations, revealed on 09/25/19, Pharmacist GG first recommended the dosage for [MEDICATION NAME] be reduced. Pharmacy recommendations for 10/30/29, 12/18/19, and 3/26/2020, recommended the same dosage reduction for [MEDICATION NAME]. The facility policy titled, Medication Regimen Review, dated 2013, instructed the facility should ensure that facility physicians/prescribers are provided with copies of the medication regimen review. The facility failed to act upon the pharmacist recommendations for this resident when they failed to provide those recommendations to the residents' physicians. This practice delayed the drug reduction for the resident for a total of 217 days.

F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 17 sampled, including six residents reviewed for unnecessary medication. Based on interview and record review, the facility failed to administer medications appropriately for one of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175214	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DIVERSICARE OF CHANUTE	**530 W 14TH STREET CHANUTE, KS 66720**

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 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 7) the six sampled residents, Resident (R) 49, when the staff administered antihypertensive medication to the resident when the monitored pulses were out of the physician's prescribed parameters, to ensure no unnecessary medication usage. Findings included: - The signed Physician order [REDACTED]. The [MEDICAL CONDITION] plan, dated 08/21/2020, instructed staff to administer medication as ordered. The POS, dated and signed 07/14/2020, documented the following physician orders: 1.) [MEDICATION NAME] (a medication used to treat high blood pressure), 10 milligrams (mg) daily [MEDICAL CONDITION] notify the physician if the resident's pulse was over 100 or less than 60, ordered on [DATE]. 2.) [MEDICATION NAME] (a medication used to treat high blood pressure), 50mg/25mg daily, [MEDICAL CONDITION] notify the physician if the resident's pulse was over 100 or less than 60, ordered on [DATE]. 3.) [MEDICATION NAME] (a medication that dilates (widens) blood vessels and improves blood flow), 5mg, 2 tablets at bedtime daily, for HTN, and notify the physician if the resident's pulse was over 100 or less than 60, ordered 05/05/2020. Review of the electronic Medication Administration Record, [REDACTED].) [MEDICATION NAME] 5mg, 2 tabs at bedtime. Staff administered the resident's medication on eight of 92 occasions when the pulse was less than 60. 2.) [MEDICATION NAME]-[MEDICATION NAME] 50-25 daily, staff administered the resident's medication on 12 of 92 occasions when the pulse was less than 60. 3.) [MEDICATION NAME] 10 mg daily, staff administered the resident's medication on 12 of 92 occasions when the pulse was less than 60. On 08/31/2020 at 12:34 PM, Licensed Nurse (LN) I confirmed staff administered the medications when the resident's documented pulses were out of the physician ordered parameters, and stated staff should not have administered the medications due to the pulse below 60. The facility failed to administer medications appropriately for R49, when the staff administered antihypertensive medication to the resident when the monitored pulses were out of the physician's prescribed parameters, to ensure no unnecessary medication usage.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** The facility reported a census of 50 residents. Based on observation, interview and record review, the facility failed to maintain an effective Quality Assessment and Assurance (QAA- facility meeting of key personal to identify issues with care and services in the facility and develop action plans to correct the concerned) program to ensure the residents of the facility received needed cares and services. Findings included: - On 09/01/20 at 04:18 PM, Administrative Staff A reported the Quality Assessment and Assurance Committee (QAA) met at a minimum of quarterly with the required attendees. He confirmed the facility's QAA Committee failed to identify the areas of deficient practice identified during the survey. The facility failed to provide adequate care and services to the residents of the facility as evidenced by the following citations: 1. Refer to F-677, the facility failed to provide appropriate oral hygiene cares for the one sampled resident, Resident (R)44. 2. Refer to F-686, the facility failed to ensure appropriate treatment and services for two of the three sampled residents, including Residents (R)44, for failure to prevent the development of four stage II PUs, and R19 regarding the worsening of a PU. 3. Refer to F-688, the facility failed to provide restorative services for three sampled Residents (R)44, R 32 and R 6, to maintain or prevent decline in range of motion (ROM) ability. The facility failed to provide R44 with the planned restorative services for at least 10 months. R44's arms became tighter with contractures, with increased difficulty to dress, and the need for increased muscle relaxant medication from the physician. 4. Refer to F-689, the facility failed to implement care planned interventions to prevent falls. Resident (R) 152, who had severe cognitive impairment, fell and experienced a spiral fractured right arm. 5. Refer to F-695, the facility failed to ensure proper cleaning of respiratory equipment for the five sampled residents, including four of the five Residents (R)11, R35, R19, and R27 regarding dirty oxygen concentrator filters; and two of the five residents, R32 and R19 regarding tubing not being replaced timely on the oxygen concentrators. 6. Refer to F-756, the pharmacy failed to identify the irregularity of the facility failure to monitor pulses which were out of parameters for Resident (R) 49, who received antihypertensive medications. In addition, the facility failed to act upon recommendations of the consultant pharmacist by failing to consistently send pharmacy recommendations to the residents' physicians for R11, R31, R35, and R6. The facility failed to identify issues with the care and services provided to the residents of the facility and failed to implement an effective action plan to correct those issue.