STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175351	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES CLAY CENTER	**715 LIBERTY PO BOX 517 CLAY CENTER, KS 67432**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 12 residents with two reviewed for dignity. Based on observation, record review, and interview, the facility failed to provide dignity and quality of life for one sampled resident, Resident (R)3. Findings included: - R3's Annual Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BI[CONDITION]) score of 15 (cognitively intact) and an indwelling urinary catheter (tube in the bladder to drain urine). The Urinary Catheter Care Plan, dated 03/05/2020, recorded staff positioned the catheter bag and tubing below the level of the bladder and away from the entrance door. On 03/05/2020 at 08:30 AM, observation revealed R3 rested in bed with the uncovered urinary catheter bag hanging on the side of the bed, with yellow urine in the catheter tubing and bag. On 03/09/2020 at 08:10 AM, observation revealed R3 rested in bed with the uncovered urinary catheter bag hanging on the side of the bed. On 0[DATE]20 at 10:00 AM, Administrative Nurse D stated the resident's urinary catheter bag should be covered at all times. The facility's Abuse, Neglect and Exploitation policy, dated September 2017, stated the residents have the right to be treated with respect, kindness and dignity which includes care and services for each resident. The facility failed to cover R3's urinary catheter bag, placing the resident at risk for embarrassment and an undignified living environment.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. Based on observation, record review, and interview, the facility failed to provide a safe, clean, comfortable environment for two of two hallways in the facility. Findings included: - On 03/09/2020 at 09:48 AM, observation during environmental tour with Administrative Staff A and Maintenance Staff (MS) U revealed the following: Front entry way with 3 foot (ft) long crack in the floor tile and the entry way floor tile with a dull finish. 100 Hallway with cracked and broken light fixture cover and another light with no cover. 200 Hallway, outside of room [ROOM NUMBER] revealed a 3 ft x 3 ft brown stain with a flaky substance. room [ROOM NUMBER]'s doorway ceiling with a 2 ft x 3 ft brown stain. room [ROOM NUMBER] floor tile in front of the bathroom door with six tiles buckled up and bent. On [DATE]20 at 10:15 AM, Administrative Staff A and MS U verified the environmental findings. Upon request, the facility lacked a preventative maintenance policy. The facility failed to provide a safe, clean, comfortable environment for two of two hallways in the facility, placing the residents in the facility at risk for an uncomfortable environment.
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 had a census of 25 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation record review and interview the facility failed to develop a comprehensive care plan for the use of an antipsychotic medication for one of five sampled residents, Resident (R) 121. Findings included: - The facility admitted R121 on 02/24/2020, the Admission Cognition Assessment recorded the resident had severely impaired cognition. The Admission Minimum Data Set, dated dated [DATE], not yet completed by the facility. The Physician Orders, dated 02/24/2020, directed the staff to administer [MEDICATION NAME] (an antidepressant medication) 25 milligrams (mg) PO (by mouth) daily for depression and [MEDICATION NAME] (an antipsychotic medication) 50 mg PO at bedtime for dementia with behavioral disturbance. R121's medical record lacked documentation of a care plan or behavior documentation to monitor the use of the antipsychotic medication. On 03/05/2020 at 09:15 AM, observation revealed the resident lying on her bed on her right side with eyes closed. On 03/09/2020 at 12:20 PM, Licensed Nurse (LN) G stated she was unsure if the resident received an antipsychotic medication. On 03/09/2020 at 02:40 PM, Administrative Nurse D verified the resident received an antipsychotic medication and verified the facility had not developed a care plan for the use of the [MEDICATION NAME] and lacked behavior monitoring and assessment. The facility's Behavior Management and [MEDICAL CONDITION] Medications policy, dated December 2017, documented the facility is to assess for appropriate diagnosis, utilization, adverse effects, and target behaviors related to [MEDICAL CONDITION] medication use. The plan of care will address individualized focus, goals and intervention directed towards managing the resident's target behaviors and non-pharmacological interventions. The facility failed to develop a care plan for the use of R121's [MEDICATION NAME], placing the resident at risk for adverse side effects.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 12 residents with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to follow up on pharmacy recommendations for two of five sampled residents, Resident (R) 14 and R121. Findings included: - R14's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had severely impaired cognition and received an antipsychotic medication (medication used to treat [MEDICAL CONDITION] and psychiatric disorders) daily. The [MEDICAL CONDITION] Medication Care Area Assessment (CAA), dated 09/29/19, recorded the resident received [MEDICATION NAME] (an antipsychotic medication) twice a day (BID). The Readmission Care Plan, dated 02/26/2020, directed staff to monitor the resident for behaviors. The care plan documented the resident received scheduled [MEDICATION NAME] for [MEDICAL CONDITION] with the following Black Box Warning (BBW-strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug): [MEDICATION NAME] is not approved for [MEDICAL CONDITION], and can increase mortality (death) risk and adverse side effects

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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) in elderly dementia residents. The Physician Order, dated 09/23/19, directed staff to administer [MEDICATION NAME], 5 milligrams (mg) PO (by mouth) BID. The September, October, November, December 2019, and January, February 2020 Monthly Pharmacy Reviews, recorded the pharmacist recommended the facility obtain an appropriate [DIAGNOSES REDACTED]. The facility did not follow up on the recommendation. On 03/05/2020 at 10:40 AM, observation revealed the resident sat in his high backed wheelchair at the nurses desk with his eyes closed. On 03/09/2020 at 01:30 PM, Nurse G verified R14 routinely received an antipsychotic medication and staff completed behavior documentation every shift. On 03/09/2020 at 02:40 PM, Administrative Nurse D verified the resident received an antipsychotic medication for the [DIAGNOSES REDACTED]. [MEDICAL CONDITION] medications are to be reviewed by the consultant pharmacist and recommendations are to be provided to the physician. The facility failed to ensure an appropriate [DIAGNOSES REDACTED]. - The facility admitted R121 on 02/24/2020. The Admission Cognition Assessment, dated 02/24/2020, recorded the resident had severely impaired cognition. The Admission MDS, dated [DATE], not yet completed by the facility. The Physician Orders, dated 02/24/2020, directed the staff to administer [MEDICATION NAME] (an antidepressant medication) 25 milligrams (mg) PO (by mouth) daily for depression and [MEDICATION NAME] (an antipsychotic medication) 50 mg PO at bedtime for dementia with behavioral disturbance. The Pharmacy Review, dated 02/27/2020, recorded the [MEDICATION NAME] had an inappropriate [DIAGNOSES REDACTED]. As of 03/10/2020, the facility had not sent the recommendation to the physician. R121's medical record lacked documentation of a care plan or behavior documentation to monitor the use of the antipsychotic medication. On 03/05/2020 at 09:15 AM, observation revealed the resident lying on her bed on her right side with eyes closed. On 03/09/2020 at 12:20 PM, Licensed Nurse (LN) G stated she was unsure if the resident received an antipsychotic medication. On 03/09/2020 at 02:40 PM, Administrative Nurse D verified the resident received an antipsychotic medication and verified the pharmacy review alerted the facility the [DIAGNOSES REDACTED]. The facility's Behavior Management and [MEDICAL CONDITION] Medications policy, dated December 2017, documented the facility is to assess for appropriate diagnosis, utilization, adverse effects, and target behaviors related to [MEDICAL CONDITION] medication use. [MEDICAL CONDITION] medications are to be reviewed by the consultant pharmacist and recommendations are to be provided to the physician. The facility failed to ensure an appropriate [DIAGNOSES REDACTED].
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** The facility had a census of 25 residents. Based on record review and interview, the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for the 25 residents who resided in the facility. Findings included: - On 03/05/2020 at 10:30 AM, review of the facility Infection Control Program revealed lack of documentation for tracking infections from August 2019 to February 2020, which included the type of infection, antibiotic usage, resolution of the infection, and additional cultures. Continued review revealed a lack of identifying, tracking, monitoring and/or reporting of infections. On 03/09/2020 at 02:10 PM, observation revealed Resident (R)18 sat in a chair in the old physical therapy room. License Nurse (LN) G removed the dressing from R18's left outer ankle, cleansed the area with skin wound cleanser, and covered the wound with a foam dressing. On 03/05/2020 at 10:45 AM, Administrative Nurse D verified the facility lacked a system to track infections from August 2019 to February 2020. The facility's Infection Management Process policy, dated December 2019, documented the process would assist the facility with preventing and managing infection events. The policy recorded infection events would be placed on the Infection Control Surveillance log to assist with monitoring types, locations, and resolution. The facility would review and evaluate infection events weekly during Risk Committee meetings and during monthly Quality Assurance and Performance Improvement Committee meetings. The facility failed to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of diseases and infection for the 25 residents who resided in the facility.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** The facility had a census of 25 residents. The sample included 12 residents with five sampled for immunizations. Based on record review and interview, the facility failed to provide documentation for three of five sampled residents pneumococcal vaccination, Resident (R) 8, R14, R3. Findings included: - On 03/05/2020 at 09:30 AM, review of R8, R14, and R3's medical records lacked documentation staff administered each resident the pneumococcal vaccination or the resident received the pneumococcal vaccination prior to admission to the facility. On 0[DATE]20 at 09:25 AM, Administrative Nurse D verified the facility lacked documentation each resident received, or staff had administered the pneumococcal vaccination to the resident. The facility's Resident Immunizations policy, dated December 2018, recorded all residents are to be offered the influenza vaccine annually during the influenza season, and pneumococcal vaccines are to be offered to all eligible residents per Centers for Disease Control (CDC) guidelines. The policy recorded the residents and responsible parties have the right to refuse any offered or physician ordered immunization. Residents and responsible parties are to be provided with education regarding benefits, potential risk and side effect of immunizations utilizing the current CDC vaccine information statements. The documentation revealed the facility would determine if the resident had received immunization outside of the facility from another provider, and immunization history from other providers would be included in the resident's clinical record. The facility failed to obtain or provide documentation that R8, R14, or R3 received the pneumococcal vaccination, placing the residents at risk to develop pneumococcal (inflammation of the lungs) infections.