STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175077	A. BUILDING _____ B. WING _____	06/15/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 35 residents and identified five with confusion and self-mobile. The sample included three sampled for adequate supervision to prevent accident hazards. Based on observation, record review and interview, the facility failed to provide adequate supervision to prevent the identified five confused self-mobile residents from going onto an empty hallway without staff knowledge, when confused self-mobile R2 went onto the empty hallway through the closed fire doors, without staff present or staff knowledge for at least 15 to 30 minutes before staff found the resident. Findings included: - The electronic medical record evidenced the facility admitted Resident (R)2 on 06/14/2017. The primary care physician documented [DIAGNOSES REDACTED]. The resident's annual Minimum Data Set (MDS), dated [DATE] revealed, the resident was unable to score on the Brief Interview for Mental Status (BIMS) due to severe cognition impairment. He required extensive assistance for transfers. He had functional limitations on one side in the upper and lower extremity and required a wheelchair for mobility. The Care Area Assessment (CAA) for cognition, dated 07/19/2019 included, the resident had a stroke in 2008 that left him with right sided weakness. He was alert and orientated to self and surroundings. He was aware of room location and recognized staff. He was non-verbal, shaking his head yes to most everything. The assessment for activities of daily living (ADLs) included, he had decreased mobility and range of motion. The Care Plan dated 03/30/2020 included, he used a high- backed wheelchair with anti-tippers and could propel himself at times. On 06/15/2020 at 2:00 PM, observation revealed the facility A hallway contained no current residents in the resident rooms. The hallway contained the beauty shop and the therapy room in use on the hallway. The far end of A hallway connected with the E-F empty hallway. On 06/15/2020 at 2:30 PM, alert and oriented resident R1 reported that recently a resident (R2) was lost in the facility and staff found him alone behind the closed fire doors on the closed A hallway. On 06/15/2020 at 6:00 PM, Certified Nurse Aide (CNA) C verified she did not see R2, on 06/03/2020 at approximately 07:00 PM, in the TV room. She started a search down A hall (empty hallway, with closed fire doors in the evenings and overnight, when the therapy staff left for the day). She located him down A hall past the closed fire doors. He had pushed the door open with his foot pedal and rolled his wheelchair through the doors. He sat in the middle of the hallway without any injury. She explained R2 had not been away from the TV room for more than 30 minutes, when the staff located him at the far end of A hall. On 06/16/2020 at 1:10 PM, Administrative Staff A reported per telephone interview, that the facility had five residents with confusion and that were self-mobile. However, the facility did not have a policy related to the closed empty A hall fire doors. Staff A explained that when the therapist finished for the day in the therapy room, past the A hall fire doors, would close the fire doors on A hallway, which was usually around 04:00 PM. The facility failed to ensure the five confused self-mobile residents did not go onto the empty hallway without staff present or staff knowledge which included confused self-mobile R2 who went through the closed fire doors onto this empty hallway without staff present or staff knowledge for at least 15 to 30 minutes.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 35 residents, with 10 reviewed for medication administration. Based on observation, record review and interview, the facility failed to ensure one Resident (R1) of the 10 residents received medications without significant medication error. On 06/08/2020 at 11:45 PM, Licensed Nurse C administered [MEDICATION NAME] 0.5 mg. (milligram) one hour and 45 minutes later than scheduled and administered [MEDICATION NAME] ER 60 Mg. at 11:45 PM, three hours and 15 minutes earlier than scheduled, to one R1 of the 10 reviewed. This resulted in two significant medication errors for R1. Findings included: - R1's electronic medical record evidenced admission on 11/28/18. The primary care physician documented [DIAGNOSES REDACTED]. Review of the annual Minimum Data Set (MDS), dated [DATE] revealed, the Brief Interview for Mental Status (BIMS) score of 14/15, indicating intact cognition. The Care Area Assessment (CAA) for pain, dated 03/28/2020 included, the resident had chronic back pain and received [MEDICATION NAME]. The resident had a history of [REDACTED]. He received antidepressants and anxiety medications daily. The Care Plan dated 05/28/2020, included the resident used an anti-anxiety medication, [MEDICATION NAME] related to anxiety disorder and [MEDICATION NAME] for chronic pain. The physician ordered on [DATE], [MEDICATION NAME] 60 milligrams (mg.), Take one tablet by mouth twice daily for pain. The resident's Medication Administration Record (MAR), indicated the pain medication as scheduled for 04:00 AM and 04:00 PM. The physician ordered on [DATE], [MEDICATION NAME] 0.5 mg., Take one tablet by mouth every 6 hours. The resident's MAR indicated it as scheduled at 04:00 AM, 10:00 AM, 04:00 PM, and 10:00 PM. The resident's narcotic tracking logs, for the [MEDICATION NAME] 60 Milligrams (mg.) and [MEDICATION NAME] 0.5 mg. both contained Licensed Nurse (LN) C's signature as removed/signed out from the narcotic lock box, on 06/08/2020 at 11:30 PM. On 06/15/2020 at 9:20 AM, R1 reported the nursing staff administered to him medication including [MEDICATION NAME] ([MEDICATION NAME]) and [MEDICATION NAME], on 06/08/2020 at 11:45 PM. He commented he then slept all day on 06/09/2020. On 06/15/2020 at 6:30 PM, LN C reported she thought on the evening of 06/08/2020, the medication aide administered R1 his [MEDICATION NAME] before she left at 08:30 PM. Then at 11:30 PM, R1 asked for his [MEDICATION NAME] and LN C checked the MAR and determined it had not been given at 08:00 PM/HS (bedtime) as scheduled. LN C then removed the [MEDICATION NAME] 0.5 mg. and the [MEDICATION NAME] 60 mg. from the narcotic locked box and administered them to R1 at 11:45 PM. When questioned as to why she administered the [MEDICATION NAME] three hours and 15 minutes before the scheduled time of 04:00 AM, she reported she did not remember giving it. However, she then verified it was her signature on the 06/08/2020 at 11:30 PM, sign out/narcotic controlled substance log. The resident's [MEDICATION NAME] was scheduled at 10:00 PM and administered at 11:45 PM, one hour and 45 minutes later than when scheduled. The facility policy for Administration of Medications, dated 04/24/19, instructed, . All medications are administered safely and appropriately per physician order [REDACTED]. A physician order [REDACTED]. (milligram) one hour and 45 minutes later than scheduled and administered [MEDICATION NAME] ER 60 mg. three hours and 15 minutes earlier than scheduled.

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.