STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175529	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEISURE HOMESTEAD AT ST JOHN	402 N SANTA FE AVENUE ST JOHN, KS 67576

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 had a census of 26 residents, with 12 residents included in the sample. Based on observation, interview, and record review, the facility failed to revise the comprehensive care plan for four residents (R) to reflect the current needs of the residents in regards to medications received, assistive devices no longer used, and oxygen therapy. (R18, R8, R14, and R22) Findings included: - Review of R18's signed Physician order [REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The resident required limited assistance of one staff with transfers, ambulation, mobility, dressing, toilet use, and bathing. The resident used a cane and wheelchair for mobility. The resident had a fracture to shoulder from fall before admission. A review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15, indicating intact cognition. The resident required supervision with transfers and ambulation. Review of the Care Area Assessment (CAA) dated 08/19/19 revealed all appropriate CAAs triggered and developed. Review of the Care Plan dated 12/03/18 and revised 02/21/20, revealed R18 had an alteration in musculoskeletal status related to [MEDICAL CONDITION] humerus. Staff were to encourage/supervise/assist R18 as needed with the use of supportive devices including a shoulder/arm immobilizer and quad cane as recommended. Review of the Physician order [REDACTED]. Observation on 08/04/20 at 02:08 PM revealed the resident sat on the side of his bed with a raised area noted to the right shoulder. R18 reported having a lot of problems in his right shoulder and minimal movement. Observation on 08/05/20 at 11:15 AM revealed the resident propelled himself in a wheelchair in the hallway. During an interview on 08/05/20 at 10:59 AM, the resident reported he did not wear a sling or immobilizer on his shoulder. He stated the doctors tried that for a while, but it did not help, so they took it off. R18 stated he tried different immobilizers, and none of them worked, and stated he used a wheelchair most of the time now. The resident reported he had a 4-wheel walker that he used when staff walked him, but never by himself because he falls. R18 stated he had not used the quad cane in a long time. During an interview on 08/05/20 at 01:49 PM, Certified Nurse Aide (CNA) C reported the resident required the assistance of one for dressing, toileting, showers, and ambulated with a walker with Physical Therapy (PT) staff. CNA C said R18 did not wear an immobilizer anymore and had not for a while, and R18 routinely used a wheelchair for mobility. During an interview on 08/05/20 at 4:00 PM, CNA E reported she did not attempt to walk the resident without his walker. CNA E stated R18 did not use a cane and was not steady enough to handle the cane. During an interview on 08/05/20 at 04:06 PM, Licensed Nurse (LN) B reported the resident received PT and could transfer with minimal assistance. The resident had some falls, usually when he was in his room and forgot to use his walker. LN B said the staff checked on R18 often and reminded him to use his call light and walker for assistance. During an interview on 08/06/20 at 10:30 AM, Administrative Nurse A reported she was responsible for the resident care plans, which she tried to review, change, and update every three months with the MDS. Administrative Nurse A reported she knew she was behind and needed to review all resident care plans. Review of the facility's policy Care Plans dated 01/2020 revealed the facility would develop and implement a comprehensive person-centered care plan for each resident following the Resident Assessment Instrument (RAI, manual used to complete the MDS assessments and care planning process) schedule. The facility failed to revise the comprehensive care plan for R18 to reflect the current needs regarding assistive devices no longer used. - Review of R22's signed Physician order [REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] identified R22 with severe cognitive impairment. The resident had delusions, physical behaviors, rejection of care, and wandering. The resident required supervision and assistance of one for cares. The resident received antipsychotic, antianxiety, and antidepressant medications seven days out of the seven day observation period. A review of the Quarterly MDS dated [DATE] revealed the resident had delusions, hallucinated, and wandered 4-6 days of the week. No changes noted with daily care assistance. The resident received antipsychotic, antianxiety, and antidepressant medications daily in the seven day observational period. A review of the Care Plan dated 08/12/19 revealed resident received [MEDICAL CONDITION] medications to include [MEDICATION NAME] (antipsychotic), [MEDICATION NAME] (antianxiety), and [MEDICATION NAME] (antidepressant) daily, which increased her risk of falling. Additionally, R22 had orders for as needed (PRN) [MEDICATION NAME] (antipsychotic) medication. Review of the Physician order [REDACTED]. Observation on 08/04/20 at 10:00 AM revealed the resident sat at a table with other residents, calm with no behaviors noted. During an interview on 08/05/20 at 04:10 PM Licensed Nurse (LN) B reported the resident had not changed in behavior since admission to the facility. During an interview on 08/06/20 at 10:30 AM, Administrative Nurse A reported she was responsible for the resident care plans, which she tried to review, change, and update every three months with the MDS. Nurse A reported she knew she was behind and needed to review all resident care plans. Review of the facility's policy Care Plans dated 01/2020 revealed the facility would develop and implement a comprehensive person-centered care plan for each resident following the Resident Assessment Instrument (RAI, manual used to complete the MDS assessments and care planning process) schedule. The facility failed to revise the comprehensive care plan for R22 to reflect the change in order for [MEDICATION NAME] medication from PRN to scheduled three times a day. - Review of R8's signed Physician order [REDACTED]. Review of the Minimum Data Set((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of eight, indicating moderate cognitive impairment. The resident required total dependence of two or more staff for bed mobility, transfers, toilet use, and personal hygiene. Special treatments procedure and programs indicated R8's use of oxygen (O2). Review of the Plan of Care dated 05/02/20 revealed R8 to observed for shortness of breath, changes in breathing or sputum. The care plan lacked interventions regarding the use of oxygen to include how often/when to apply, liter rate, and information on changing the tubing to the concentrator. Review of the Hospice Order dated 07/28/20 revealed oxygen to run at 2-4 liters as needed (PRN) for shortness of air. Observation 08/04/20 at 09:37 AM revealed R8 in the recliner and oxygen tubing on R8 running at 2 liters per nasal cannula. Interview on 08/05/20 at 12:40 PM with Certified Nurse Aide (CNA) C, revealed she placed the O2 on R8 when he was in his room because he tended to breath heavier and CNA C thought it helped him. Interview on 08/05/20 at 03:13 PM with Licensed Nurse (LN) B reported the O2 tubing was changed every Sunday along with the humidifier and nebulizer tubing. LN B stated the tubing and humidifier were dated when they were changed and charted on the treatment record. Interview on 08/06/20 at 10:36 AM with Administrative Nurse A revealed Administrative Nurse A would review the Plan of Care every three months, but stated she did get behind but did put the new stuff (care plan items) on the plan of care but did not always remove the old stuff (care plan items). Administrative Nurse A stated she did know the Treatment Administration Record and the plan of care did not contain the oxygen order for R8 until 08/05/20. Review of the facility Care Plan Policy revised on 01/2020 revealed the comprehensive person-centered care plan would include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The facility failed to revise

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) R8's care plan regarding his use of oxygen. - Review of R14's signed Physician order [REDACTED]. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] identified R14 with short-term and long- term memory problems. R14 received antianxiety medication daily in the seven day review period. Review of the Annual Minimum Data Set ((MDS) dated [DATE] identified the resident with continued short-term and long-term memory problems. R14 received antianxiety medication daily of the seven day review period. Review of the Care Plan dated 10/13/2017 revealed R14 with mood problems related to dementia with behaviors and became more confused and agitated in the late afternoon into the evening. R14 receives [MEDICATION NAME] (an antianxiety medication) as needed (PRN). The care plan identified R14 as resistant with care due to dementia with behaviors and instructed staff to allow R14 to make decisions about treatment regime to provide a sense of control. The care plan noted R14 had the potential to demonstrate verbally and physically negative behaviors related to demetia with behaviors A review of R14's medical record revealed the [MEDICATION NAME] was discontinued on 08/29/18. Observation on 08/05/20 at 10:48 AM revealed CNA C and CNA D assisted the resident with toileting cares and the resident exhibited no behaviors such as kicking, biting, or hitting. Interview on 08/05/20 at 12:40 PM with CNA C revealed the care plans were located on the electronic charting system which indicated the care each resident required, and stated the updates were completed by the Director of Nursing or the Social Services staff. Interview on 08/05/20 at 01:50 PM with CNA D revealed the resident did have behaviors when staff provided care such as toileting. CNA D stated R14 would kick, hit, and bite. CNA D stated those behaviors were reported to the nurse. Interview on 08/05/20 at 03:19 PM with Licensed Nurse (LN) B revealed R14 did not receive [MEDICATION NAME] and had not for a while. LN B said Administrative Nurse A revised and updated the care plan in conjunction with the resident and their family. Interview on 08/06/20 at 10:39 AM with Administrative Nurse A revealed she reviewed the care plans every three months; however, she did get behind at times. She does ensure that all new interventions are on the care plans, but she does not always get the old interventions removed. Review of the Care Plan Policy revised on 01/2020 revealed the Comprehensive person-centered care plan would include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment. The facility failed to revise the care plan in regards to the discontinuation of R14's [MEDICATION NAME] medication.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** The facility census totaled 26 residents. The facility prepared all the food in the central kitchen. Based on observation, interview, and record review the facility failed to store and serve food items in a sanitary manner as evidenced by: the failure to label food items with an open date, failure to store dry goods to ensure closure of bags, failure to ensure dietary staff wore appropriate hair coverings, and failure to clean the blender container between pureed food items. These failures had the potential to affect all residents. Findings included: - Observation on 08/03/20 at 08:51 AM in the dry storage area, revealed undated muffin mix and powder sugar bags open with no securing devices to ensure the bags remained closed. Observation of the refrigerator revealed a bowl of lettuce with no date marked on the covering and no open date on a bag of shredded cheese. Interview on 08/03/20 at 10:30 AM with Certified Dietary Manager (CDM) H revealed she had attempted to educate staff about the need to date and securely close items. The facility Nutrition Services Department policy dated 02/12/20 revealed items such as flour, sugar, cornstarch, non-fat dry milk, and shortening were to be stored in tightly covered containers labeled with the item name. The facility failed to store food items in a sanitary manner by the failure to secure and label all food items properly. - Observation on 08/03/20 at 08:51 AM revealed Dietary Staff (DS) F in the kitchen area without a hair net. Subsequent interview on 08/03/20 with DS F revealed she forgot to put on a hairnet. Interview on 08/03/20 at 10:30 AM with CDM H revealed she attempted to educate the staff on proper hair net usage, and she would be re-educating the staff. The facility Nutrition Services Department policy date 02/12/20 revealed hair nets were to cover all hair completely. The facility failed to ensure DS F restrained her hair with a hair net while in the food preparation area of the kitchen. - Observation on 08/04/20 at 11:40 AM revealed DS G pureed swiss steak for residents requiring a pureed diet in a blender. She then rinsed the blender with water and then placed potatoes into the blender, without thoroughly washing the container with soap. Interview on 08/04/20 at 11:40 AM with DS G revealed she usually washed the blender with soap and water between food items, but due to being observed, she was nervous and forgot. Interview on 08/03/20 at 10:30 AM with CDM H revealed the staff were aware they needed to wash the blender in between food items. The facilities policy for Pureed Diet Orders dated 02/12/20 lacked information regarding cleaning the blender after each pureed item. The facility failed to ensure that dietary staff cleansed the blender container between pureed food items.