STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175313	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDICALODGES ARKANSAS CITY	203 E OSAGE AVENUE ARKANSAS CITY, KS 67005

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 0688 **Level of harm** - Minimal harm or potential for 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 identified a census of 40 residents, with 11 residents sampled, including three residents reviewed for restorative services. Based on on observation, record review and interview, the facility failed to provide restorative services for the three residents Resident (R)1, R2, R3, to maintain or prevent decline in range of motion ability. Findings Included: - The Physician order [REDACTED]. The Annual Minimum Data Set (MDS) Assessment, dated 10/19/2019, documented R1 had severely impaired cognition. She required total assistance for bed mobility and transfer and had limitation in Range of Motion (ROM) in all extremities. The Care Area Assessment (CAA) for Activity of Daily Living (ADL), dated 10/19/2020, indicated that decline is expected due to R1's disease process. The care plan for mobility, dated 02/15/2020, instructed staff that R1 was on a restorative nursing program for Active Range of Motion (AROM) to the Right Upper Extremity (RUE), Passive Range of Motion (PROM) to the left Upper Extremity (LUE) and stretching to left and right knees, ankles and hips. The Restorative Nursing Assessment, dated 07/07/2020, indicated the restorative exercises for R1 as performed three to six times weekly. Review of R1's restorative nursing program documentation in Point Click Care (PCC), from 06/29/2020 to 07/28/2020, revealed the resident received restorative exercises on only seven of the 30 days period. On 07/27/2020 at 04:22 PM, R1 sat in her room in a wheelchair. The resident had contractures (abnormal permanent fixation of a joint) to her elbows, hands and knees. On 07/28/2020 at 11:35 AM Certified Nurse Aide (CNA) Q stated R1 has contractures and that restorative exercises are performed by the Restorative Aide. On 07/28/2020 at 12:06 PM, CNA MM stated R1 does not receive range of motion, other than what normally happens during the care given, unless the schedule indicates Restorative Aide duties. On 07/28/2020 at 01:21 PM Administrative Nurse D stated the Restorative Aide position is scheduled. Review of the facility Date Range Schedule, for 07/26/2020 to 08/01/2020 identified a Restorative Aide scheduled on only two of the 7 days. The facility policy titled Restorative Program Policy and Procedure, revised 12/2018, instructs the restorative program will be provided to each resident based on their individual needs. The facility failed to provide restorative services for this dependent resident with contractures to maintain and prevent decline in her range of motion ability. - The Physician order [REDACTED]. She was totally dependent for transfer and required extensive assistance for bed mobility. She had limited range of motion (ROM) in her legs. The Care Area Assessment CAA for Activities of Daily Living, dated 05/29/2020, evidenced R2 was recently on therapy because of weakness. The care plan for mobility, dated 02/15/2020, instructed staff R2 was on a restorative nursing program for active range of motion (AROM) for bilateral upper extremities (BUE both arms). The Restorative Nursing Assessment, dated 06/08/2020, indicated AROM BUE six times weekly. Review of R2's restorative nursing program documentation in Point Click Care, from 06/29/2020 to 07/28/2020 revealed the resident received restorative exercises on only four of the 30 days. On 07/27/2020 at 03:50 PM R2 was in her room in her wheelchair. She had foot drop (difficulty lifting the front part of the foot) and her toes were lightly touching the padded footrest. On 07/28/2020 at 12:50 PM Certified Nurse Aide () P stated the facility had a restorative aide. CNA P does not do restorative with residents. On 07/28/2020 at 01:21 PM Administrative Nurse D stated recommendations for a resident's restorative program are given by therapy. On 07/28/2020 at 03:37 PM CNA NN stated range of motion and restorative exercises are not performed during cares. The facility policy titled Restorative Program Policy and Procedure, revised 12/2018, instructs the restorative program will be provided to each resident based on their individual needs. The facility failed to provide restorative services for this dependent resident to maintain and prevent decline in her range of motion ability. - The Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented R3's cognition through staff assessment was severely impaired. R3 was dependent and required the assist of two staff for bed mobility and transfer. The Activities of Daily Living Care Area Assessment, dated 12/21/2019, assessed R3 as having ROM deficits in both upper and lower extremities. The care plan for mobility, dated 1/24/2020, instructed staff that R3 was on a restorative nursing program for passive range of motion (PROM) and positioning . The Restorative Nursing Assessment, dated 06/18/2020, indicated staff should provide the restorative PROM exercises for R3 three to six times weekly. Review of R3's restorative nursing program documentation in Point Click Care (PCC) from 06/29/2020 to 07/28/2020 revealed the resident received restorative PROM exercises on only four of the 30 days. On 07/27/2020 at 04:13 PM R3 sat on a cushion in his high back wheelchair. He had a rolled washcloth clutched in each hand, and his forearms rested in padded arm cradles. He had a foam cushion between his thighs and padded footrest. He maintained his position in the chair. On 07/28/2020 at 11:26 AM (Certified Nurse Aide) CNA Q stated the resident was pretty stiff and staff perform his cares. CNAs do not perform restorative exercises but there was a restorative aide who does. On 07/28/2020 at 11:30 AM CNA MM stated residents receive restorative exercises when a Restorative Aide is scheduled. On those days, as many as can be done in the day are done. There was no one scheduled today. On 07/28/2020 at 01:21 PM Administrative Nurse D stated there was a restorative book that the Restorative Nurse goes over with the Restorative Aide. The Restorative Aide is scheduled from 04:30 AM to 01:00 PM. The restorative aide works with residents when they are awake, he or she doesn't wake them up, but some of the residents get up early. On 07/28/2020 at 03:44 PM CNA NN stated R3 is immobile and needs staff to move him. CNA NN does not perform restorative exercises with the residents. On 07/29/2020 at 09:16 AM CNA OO stated the restorative aide does restorative. On 07/29/2020 at 09:34 AM CNA MM stated there were no times when staff completed restorative on scheduled shifts that staff did not document it as completed. The facility policy titled Restorative Program Policy and Procedure, revised 12/2018, instructs the restorative program will be provided to each resident based on their individual needs. The facility failed to provide restorative services for this dependent resident with contractures to maintain and prevent his further decline in range of motion ability.
F 0689 **Level of harm** - Minimal harm or potential for 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 40 residents with 11 residents sampled, including three residents sampled for accidents. Based on interview, record review, and observation, the facility failed to implement an appropriate fall intervention for one of the three sampled residents, Resident (R) 5, following a fall, to prevent further falls. Findings included: - The Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status Score (BIMS) of 7, indicating the resident was severely cognitively impaired. She required extensive assistance of two staff for bed mobility and transfers. Her balance was unsteady and she was only able to stabilize with staff assistance. She used a walker and/or a wheelchair for locomotion. She had one non-injury fall since her prior

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) assessment. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/17/20, documented the resident with impaired cognition, very poor memory, and difficulty following what was being said to her. The Falls CAA, dated 07/17/20, documented the resident was at risk for falls due to a history of falls, weakness and [MEDICAL CONDITION]. The quarterly MDS, dated [DATE], documented the resident had a BIMS score of 8, indicating moderately impaired cognition. She required extensive assistance of one staff for bed mobility and transfers. She had unsteady balance and was only able to stabilize with staff assistance, no impairment in functional range of motion (ROM) and used a wheelchair for locomotion. She had one non-injury fall since the prior assessment. The Falls Care Plan, dated 07/15/20, instructed staff the resident was at risk for falls related to altered cognition and weakness. Review of the resident's medical record in Point Click Care (PCC), an electronic documentation system, under the Assessments tab, revealed fall assessments completed on 07/08/20, 07/02/20, and 03/05/20, which all indicated the resident was at a moderate risk for falls. Review of the resident's medical record in PCC, under the Progress Notes, dated 07/04/20, revealed the resident had a non-injury fall while in her room. The resident reported to staff she was trying to go to the bathroom. The facility's new intervention for the fall was to educate the resident of the importance of using the call light to request help. The resident's impaired cognition made this intervention inappropriate as she could not remember to be educated in this manner. On 07/28/20 at 01:20 PM, Certified Nurse Aide (CNA) P, assisted the resident from the dining room to her room via the wheelchair. The resident was able to propel herself in the wheelchair by using her feet and with staff encouragement. The resident was wearing appropriate footwear at that time. CNA P handed the resident her call light before leaving the room. On 07/28/20 at 01:20 PM, CNA P stated the resident had confusion and did not always remember to use her call light. On 07/29/20 at 09:10 AM, CNA M stated the resident's fall interventions included using gripper socks while she was in bed and toileting her frequently. The resident was most often confused. On 07/29/20 at 08:01 AM, Licensed Nurse (LN) G stated, an intervention should be initiated at the time of the fall and needed to be relevant to the fall and appropriate for the resident. Reminding the resident to use the call light would not be appropriate for this resident as she had confusion. On 07/29/20 at 09:17 AM, Administrative Nurse D stated, the resident can be confused at times due to having a [DIAGNOSES REDACTED]. The facility failed to implement an appropriate intervention to prevent further falls, following a fall, for this dependent resident with [MEDICAL CONDITION].
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents with 11 residents sampled, including one resident sampled for urinary incontinence (involuntary passage of urine). Based on observation, interview, and record review, the facility failed to properly perform perineal hygiene for the one sampled Resident (R)8, to prevent potential urinary tract infections. 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 00, indicating he had severe cognitive impairment. The resident required extensive assistance of two staff for toilet use and extensive assistance of one staff for personal hygiene. He was frequently incontinent (inability to hold urine) of bladder. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 02/11/20, documented the resident was frequently incontinent of bladder and required extensive assistance for toileting. The MDS, dated [DATE], documented the staff assessment for cognition revealed the resident had moderately impaired cognition. He required extensive assistance of two staff for toileting and extensive assistance of one staff for personal hygiene. He was always incontinent of bladder. The risk for skin breakdown care plan, dated 05/12/20, instructed staff the resident was frequently incontinent of bladder. Staff were to check, clean, and change the resident every two hours and as needed. On 07/28/20 at 11:14 AM, Certified Nurse Aide (CNA) Q and MM, entered R 8's room to perform peri-care. Staff removed the resident's wet brief and placed a clean brief on the resident. Staff did not perform peri-care after removing the soiled brief or before placing on a clean brief. On 07/28/20 at 11:14 AM, CNA Q stated, she failed to perform peri-care after removing the resident's wet brief but should have done so. On 07/29/20 at 09:17 AM, Administrative Nurse D stated, peri-care should always be done when changing a wet brief and before putting on a clean, dry brief. The undated facility policy for Peri-care, included: Staff should remove the soiled brief and wipe the urethral opening in one circle and cleanse down the front of the penis. The facility failed to perform peri-care on this male resident, following removal of a wet incontinence brief and before application of a new brief, to prevent urinary tract infections for this resident at risk for infection.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** The facility reported a census of 40 residents with 11 residents sampled. Based on observation, record review, and interview, the facility failed to require staff to properly wear facial masks to prevent the spread of potential infections in the facility and failed to sanitize/replace oxygen tubing which came into direct contact with the floor to prevent respiratory infections before reapplying it to one sampled resident, Resident (R) 4. Findings included: - On 07/27/20 at 02:15 PM, Certified Nurse Aide (CNA) O, opened the locked front door to allow Surveyor I entrance into the building. CNA O had on a face mask covering only her mouth. The face mask did not cover her nose. On 07/27/20 at 02:48 PM, CNA N was checking resident call lights in resident rooms. CNA N had on a face mask covering only his mouth. The face mask did not cover his nose. On 07/27/20 at 10:12 AM, CNA O stated she had not been wearing her face mask properly when she opened the locked door for Surveyor I. Staff O confirmed the face mask needed to cover both her mouth and nose for it to be worn properly to prevent the spread of infections. On 07/27/20 at 02:48 PM, CNA N stated he had not been wearing his face mask properly while going into multiple resident rooms to check the functioning of the call lights. Staff N confirmed the face mask needed to cover both his mouth and nose for it to be worn properly to prevent the spread of infections. On 07/29/20 at 09:17 AM, Administrative Nurse D stated, the proper way to wear a face mask was to ensure the mouth and nose are both covered. Staff have been educated on the correct way to wear face masks. The facility instructions for staff on How to Wear a Mask, dated 04/17/20, included: Do not wear the face mask below your nose. The facility failed to ensure staff properly wore facial masks, to prevent the spread of potential Covid 19 infections to the residents of the facility. Furthermore, on 07/29/20 at 09:02 AM, Certified Nurse Aide (CNA) N, assisted Resident (R) 4 to her room following breakfast. Once the resident was in her recliner, staff N went back to the dining room to get the resident's oxygen concentrator. The oxygen tubing and nasal canula rested directly on the dining room floor. Staff N gathered up the tubing and took the oxygen concentrator to the resident's room. Once in the resident's room, staff N dropped the tubing onto the floor in order to plug in the oxygen concentrator. He then picked up the tubing and began to place the nasal canula on the resident. Surveyor I stopped staff N from applying the nasal canula to the resident's nose. On 07/29/20 at 09:02 AM, CNA N stated, he had noticed the resident's oxygen tubing had been on the floor but was in the process of putting the oxygen on her anyway. Staff N confirmed he should have changed the tubing before putting it on the resident. On 07/29/20 at 09:17 AM, Administrative Nurse D stated, the oxygen tubing and nasal canula should be replaced when it was on the floor. A facility policy for oxygen tubing was not made available at the time of the survey. The facility failed to replace oxygen tubing which came into direct contact with the floor, placing this resident at risk for respiratory infections.