STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175157	A. Building B. Wing	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Andover	621 W 21st Andover, KS 67002

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. The facility reported a census of 93 residents. The sample included three residents. Based on interview and record review the facility failed to assess for pain and take action to manage severe pain for Resident (R)1. Additionally, the facility failed to communicate R1's pain between her nurses, doctors, and other healthcare providers. As a result of the deficient practice, R1 had severe pain with ineffective pain relief for six days. This deficient practice also placed R1 at risk for discomfort and further decline in her overall well-being. Findings included: - R1's Electronic Health Record (EHR) included diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), and chronic pain. R1's 11/02/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R1 was dependent on staff for all activities of daily living (ADL). The MDS documented R1 had impairment of both the upper and lower extremities on one side. The MDS documented R1 received routine medications and did not receive as needed pain medications or non-medicated pain interventions during the observation period. The MDS noted R1 did not report pain during the interview. The MDS documented R1 received opioid (a class of controlled drugs used to treat pain) medication during the observation period. R1's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 11/08/24 documented R1 triggered due to orientation, memory, and recall deficits noted during the BIMS interview. The CAA noted R1's risk factors included self-care deficits, falls, and injuries. The CAA noted the care plan would reflect the resident's current cognitive status, ADL status, encourage active participation in facility functions, maintain communication, decrease fall and pressure ulcer risk, and maintain R1's dietary intake and hydration status. The Pain CAA did not trigger on the MDS. R1's 05/05/25 Quarterly MDS documented a BIMS score of zero, which indicated severely impaired cognition. The MDS documented R1 as dependent on staff for all activities of daily living (ADL). The MDS documented R1 had impairment of both the upper and lower extremities on one side. The MDS documented R1 received routine medications and as-needed pain medications: R1 did not receive non-medicated pain interventions during the observation period. The MDS documented R1 received opioid medication. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan dated 05/23/23 directed staff to evaluate the effectiveness of R1's pain interventions and administer pain medications as ordered. The plan dated 10/10/23 directed staff to provide non-pharmacological pain interventions including diversional activities, massage, quiet environment, and repositioning. The plan, dated 11/15/23, directed staff to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. The plan directed staff to notify the physician if the interventions were unsuccessful or if R1's complaint was a significant change from the resident's past experience of pain. The plan directed staff to observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decreased range of motion, and/or withdrawal or resistance to care. The plan directed staff to report to the nurse a loss of appetite, refusal to eat, and weight loss. R1's Physician Orders documented the following orders: Acetaminophen (over-the-counter pain medication) oral tablet 325 milligrams (mg), give two tablets by mouth at bedtime for back pain, dated 12/14/23. Acetaminophen oral tablet 325 mg, give two tablets by mouth every six hours as needed for pain, dated 12/14/23. Hydrocodone-acetaminophen (opioid medication use to treat severe pain) oral tablet 5-325 mg, give one tablet by mouth every six hours as needed for pain, date ordered 01/15/24. Hydrocodone-acetaminophen oral tablet 5-325 mg, give one tablet by mouth two times a day for arthritis pain, date ordered 01/15/24. R1's Progress Note dated 04/30/25 at 12:47 PM documented R1 cried out in pain in the dining room. The note documented staff noted R1's left arm was behind her in a wheelchair and R1 hollered out loudly in pain when her arm was touched. The note documented R1 had edema (swelling resulting from an excessive accumulation of fluid in the body tissues) on her left elbow. Staff notified R1's physician and received an order for an X-ray of R1's left humerus (upper arm bone) and left elbow immediately. The Progress Note dated 04/30/25 at 04:10 PM, documented the X-ray results were negative. The X-ray Reports dated 04/30/25 documented no fractures (broken bone) of the left elbow or left humerus. The Provider Progress Note dated 05/01/25 at 10:25 AM documented R1 hurt her left elbow after being repositioned in the wheelchair. The noted documented the X-rays showed no acute displaced fractures. The note recorded R1 had acetaminophen 325 mg two tablets by mouth every six hours for pain and R1 had left-side weakness and received supportive care. The Progress Note dated 05/05/25 at 03:05 PM documented R1 had a shower, and no new concerns were noted. The Progress Note dated 05/21/25 at 02:09 PM documented R1 received a shower that day and recorded R1 had yellow bruises on her chest area and the nurse was aware. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The Orders Administration Note dated 05/23/25 at 04:14 PM, documented R1 exhibited uncontrolled crying and poor oral intake. The note lacked mention of any actions taken or follow-up assessment for ongoing pain. The Orders Administration Note dated 05/24/25 at 09:39 AM, documented R1 exhibited uncontrolled crying and poor oral intake. The note lacked mention of any actions taken or follow-up assessment for ongoing pain. The Orders Administration Note dated 05/25/25 at 11:33 AM, documented R1 received acetaminophen 325 mg, two tablets by mouth as needed for pain. The Orders Administration Note dated 05/25/25 at 12:29 PM, documented the as needed acetaminophen was ineffective. R1's record lacked evidence of further actions or pain management interventions implemented in response to the ineffective medication. The Orders Administration Note dated 05/26/25 at 08:08 AM, documented R1's scheduled (two times daily) hydrocodone-acetaminophen tablet 5-325 mg ran out. The pharmacy was unable to provide a code to remove the medication from the emergency kit due to the need for a new signed prescription from the physician. The note documented staff placed the request for a new prescription in the MD Book to notify the physician. The Orders Administration Note dated 05/26/25 at 06:24 PM, documented staff notified the provider via phone regarding R1's need for a new hydrocodone prescription. The note documented the facility received the medication and R1 would receive a scheduled dose that night. The Orders Administration Note dated 05/28/25 at 03:39 PM, documented R1 exhibited uncontrolled crying and poor oral intake. The note lacked mention of any actions taken or follow-up assessment for ongoing pain. The Order Note dated 05/29/25 at 10:0 AM, documented the provider was in the facility to see R1 and provided new orders. The note documented the orders discontinued the current acetaminophen order and started acetaminophen 325 mg two tablets by mouth twice a day scheduled, and as needed, every six hours for pain. R1's May 2025 Medication Administration Record (MAR) revealed the facility administered as needed acetaminophen 325 mg tablet two by mouth every six hours on 05/05/25 and was effective. The facility also administered as needed acetaminophen on 05/25/25 and noted it was ineffective. R1 received hydrocodone-acetaminophen oral tablet 5-325 mg, give one tablet by mouth every six hours as needed for pain, one time on 05/28/25, which staff documented as effective. The Progress Note dated 05/29/25 at 06:01 PM, documented the X-ray results showed an acute mildly displaced fracture of the surgical neck of the proximal (nearer to a point of reference or attachment) left humerus, new to the prior X-ray results. The Progress Note dated 05/29/25 documented R1's pain would be managed by as needed narcotics. The staff notified the provider of R1's excruciating pain on Friday (05/23/25) and staff monitored R1 and administered medications. The note documented staff received a new order that day to obtain X-rays of R1's left humerus and to send her to the hospital. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R1's Hospital Report dated 05/29/25 at 10:47 PM, documented R1 had an acute comminuted (a fracture where the bone breaks into three or more pieces due to a sudden, traumatic injury) fracture of the left humerus neck. The Progress Note dated 05/30/25 at 09:22 AM, documented R1 returned from the hospital. R1 did not require surgery but R1 was to wear a sling on her left arm and follow up with an orthopedic physician (bone doctor) the following week. R1's May 2025 Treatment Administration Record (TAR) documented an order for a pain level every shift, day and night, using a 0-10 pain scale (zero indicating no pain and 10 the worst pain imaginable). Both day and night pain levels for 05/01/25 through 05/28/25 documented the resident had no pain. The night pain level for 05/28/25 and day pain level for 05/30//25 noted the resident was hospitalized . The night pain level for 05/30/25 noted the resident had no pain. The day pain level for 05/31/25 noted R1's pain was four and the night pain level for the same day recorded R1 had no pain. During an interview on 06/03/25 at 11:00 AM, Certified Medication Aide (CMA) R reported as needed medications would be given under the direction of a Licensed Nurse (LN). CMA R reported if a resident's pain medication was not effective the resident would be assessed by the LN and the LN would direct staff what needed to be provided to the resident. CMA R reported if the resident had another as needed medication that could be administered, the LN would give the direction to administer the medication. CMA R reported she could not say if R1 had pain issues as CMA R had not worked in R1's hallway. During an interview on 06/03/25 at 11:29 AM, Certified Nurse Aide (CNA) M reported R1 discharged that morning. CNA M reported R1 was very stiff to move, the left was R1's weak side, and she would stiffen up during showers and transfers. CNA M reported R1 would hold her left arm on her stomach during movements. CMA M reported R1 had pain, but once she received her medications, she was okay. CMA M reported she noticed R1 had an increase in pain in the past couple of weeks before the fracture was noted. CNA M reported R1 screamed out in pain quite loudly on her shower day, and CNA M reported that to the nurse. CNA M reported she always let a nurse know if a resident was in pain. During an interview on 06/03/25 at 12:25 PM, CNA N reported she was in the dining room when R1 hollered out in pain because R1's left arm was behind her. CNA N reported she gently moved R1's arm from behind the resident that day. During an interview on 06/03/25 at 05:00 PM, LN G reported she verbally told the provider on 05/23/25 about R1's excruciating pain when the provider was in the facility. LN G reported she forgot to document that in the EHR because she was quite busy. LN G reported she noticed R1 was not eating well and the resident did cry so that is why she documented the behavior notes for the dates 05/23/25, 05/24/25, and 05/28/25. LN G said she could not recall if she had finished the progress notes as she reported she was busy and sometimes she forgot. LN G reported R1's hydrocodone was discontinued and why she did not give the resident any as needed hydrocodone after she gave the ineffective acetaminophen on 05/25/25. LN G verified the acetaminophen was ineffective and said she must have forgotten to follow up on any documentation. LN G reported R1 received routine pain medication the morning of 05/23/25 therefore she felt it was too soon to give R1 more pain medication at 12:30 PM. LN G reported other nurses knew R1 had increased pain since 05/23/25 and said it would be documented in the Team Health Book at the nurse's station, since the provider was in the facility almost daily. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/03/25 at 11:38 AM, Administrative Nurse E reported R1 had pain when staff transferred her with the mechanical lift but once she was transferred, she was fine. Administrative Nurse E said R1's body would stiffen because she had contractures (abnormal fixation of muscles or joints). Administrative Nurse E reported she noted around the beginning of May, R1 complained of left arm pain and had some swelling. Administrative Nurse E said an X-ray was negative. Administrative Nurse E reported she was not R1's direct care nurse so she did not know if R1 had any other discomfort. Administrative Nurse E reported if a pain medication was not effective, the nurse would notify the provider with a phone call. During an interview on 06/03/25 at 04:09 PM, Administrative Nurse D was not sure if the fracture was related to the incident on 04/30/25 for R1 as she had an open investigation for the fracture. Administrative Nurse D reported she expected the nurse to call the physician if a pain intervention was ineffective, or if the resident was experiencing increased pain, the nurse should call the provider and document that in the EHR. Administrative Nurse D reviewed R1's documentation in EHR for the three behavior notes that LN G documented uncontrolled crying and poor oral intake and reported she expected the nurses to complete a progress note on what interventions were completed and if they were effective or ineffective and document what was done for the resident. Administrative Nurse D said she expected the nurses to complete that documentation. During an interview on 06/03/25 at 05:15 PM Administrative Nurse D sat at the nursing station in the 200 hallway and reviewed the Team Health Book. Administrative Nurse D verified the book lacked any documentation about R1's increased pain in the month of May until 05/26/25 which was regarding the prescription that was needed for R1's hydrocodone refill. Administrative Nurse D reported the provider was generally in the facility every day and would look at the book. She further stated the provider was currently on vacation so she could not contact him until next week but went on to say that when the provider assessed R1 on 05/29/25, he changed the medication orders for pain and ordered the X-ray. Administrative Nurse D reported that R1's pain not being addressed the week prior to the fracture was a concern. The facility's Pain Assessment and Management dated 04/22/25 documented the facility must ensure pain management to each resident who requires such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.