

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Tonganoxie Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 East Street Tonganoxie, KS 66086	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168</p> <p>The facility had a census of 85 residents. The sample included 18 residents with four reviewed for abuse. Based on observation, record review, and interview the facility failed to ensure staff identified injuries of unknown origin as potential allegations of abuse and report to the administrator to investigate. This placed the residents at risk for unidentified and ongoing abuse and/or mistreatment.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R46's Electronic Medical Record (EMR) documented the resident had diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid,) diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), dementia (progressive mental disorder characterized by failing memory, and confusion), and anxiety. <p>R46's Quarterly Minimum Data Set (MDS) dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) of three indicating severely impaired cognition. The MDS recorded the resident was dependent on staff for most activities of daily living (ADLs). The MDS recorded the resident required substantial to maximum staff assistance with all transfers and used a wheelchair for mobility.</p> <p>R46's Fall Risk Assessment, dated 10/04/23, recorded a score of 13.0 which indicated a risk for falls.</p> <p>R46's Care Plan, dated 11/07/23, directed staff to utilize a pressure-reducing mattress and cushion to the wheelchair, and fold the back or remove the wheelchair leg rest before transfer. The plan directed staff to keep R46's skin clean and dry. The care plan documented the resident needed a safe environment with even floors free from spills and or clutter, glare-free light, and a working and reachable call light. The care plan instructed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurses Note, dated 10/25/23 at 10:44 AM, documented R46 had a large skin tear to her right lower extremity that was bleeding. There was a skin flap present and the flap covered the entire tear. R45 had an area that measured 9.4 centimeters (cm) by 2.0 cm. Staff cleansed the area and the skin flap was approximated; a dressing was applied. R46's behavior indicated mild discomfort that subsided once the dressing was applied. Staff observed no other injuries to R46's legs. A skin assessment was completed from head to toe and noted a small healing abrasion to R46's left upper thigh. The physician and the resident's representative were notified.</p> <p>The Nurses Notes, dated 12/19/23 at 08:20 PM, documented R46 had a skin tear on her right lateral (outer side)calf. The area was 4.0 cm in length and the top layer of skin was peeled back and was in the shape of a triangle. Staff approximated the skin with three Steri-strips (adhesive closures) and a dry dressing R46 had no bleeding, swelling, or pain.</p> <p>R46's EMR lacked any investigative notes regarding the incident. The facility was unable to provide evidence an investigation was completed.</p> <p>On 03/20/24 at 10:10 AM, observation revealed the resident sat in the living room in a wheelchair, dressed in capri pants and anti-slip socks. Continued observation revealed the resident had her right foot off the wheelchair foot pedal. R46's bilateral lower legs revealed no skin issues or open areas. R46 had a scar from a recent skin injury to her left calf and shin area.</p> <p>On 03/20/24 at 10:00 AM, Administrative Nurse D stated the medical records documented the resident had a skin tear on 10/25/23 and 12/19/23 but Administrative Nurse D stated administrative staff was unaware of how the injuries occurred. Administrative Nurse D verified the facility did not investigate to try to determine the cause of the injuries.</p> <p>The facility's Accident and Incidents-Investigating and Reporting policy, dated July 2017, documented that all accidents or incidents involving residents, employees, visitors, and vendors occurring on the facility premises shall be investigated and reported to the administrator. The nurse supervisor, charge nurse, or supervisor would promptly initiate and document an investigation of the accident or incident. The following data would be included on the Report of Incident or Accident form:</p> <p>The nature of the injury or illness and the circumstances surrounding the accident or incident; the name of the witness and their accounts of the accident or incident; any corrective actions taken. The nurse supervisor, charge nurse, department director, or supervisor would complete a Report of Incident or Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident.</p> <p>The director of nursing services shall ensure that the administrator receives a copy of the Report of Incident or Accident form for each occurrence. The report would be reviewed by the safety committee for trends related to accidents or safety hazards in the facility and to analyze individual resident vulnerabilities.</p> <p>The facility staff failed to identify R46's injuries of unknown origin as possible abuse, neglect, or mistreatment and report to the facility's administrator as required. This placed R46 at risk for unidentified and ongoing abuse and/or neglect</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168</p> <p>The facility had a census of 85 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to investigate Resident (R)46's injuries of unknown origin to rule out possible abuse or neglect. This placed the residents at risk for unidentified and ongoing abuse or neglect.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R46's Electronic Medical Record (EMR) documented the resident had diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid,) diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), dementia (progressive mental disorder characterized by failing memory, and confusion), and anxiety. <p>R46's Quarterly Minimum Data Set (MDS) dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) of three indicating severely impaired cognition. The MDS recorded the resident was dependent on staff for most activities of daily living (ADLs). The MDS recorded the resident required substantial to maximum staff assistance with all transfers and used a wheelchair for mobility.</p> <p>R46's Fall Risk Assessment, dated 10/04/23, recorded a score of 13.0 which indicated a risk for falls.</p> <p>R46's Care Plan, dated 11/07/23, directed staff to utilize a pressure-reducing mattress and cushion to the wheelchair, and fold the back or remove the wheelchair leg rest before transfer. The plan directed staff to keep R46's skin clean and dry. The care plan documented the resident needed a safe environment with even floors free from spills and or clutter, glare-free light, and a working and reachable call light. The care plan instructed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface</p> <p>The Nurses Note, dated 10/25/23 at 10:44 AM, documented R46 had a large skin tear to her right lower extremity that was bleeding. There was a skin flap present and the flap covered the entire tear. R46 had an area that measured 9.4 centimeters (cm) by 2.0 cm. Staff cleansed the area and the skin flap was approximated; a dressing was applied. R46's behavior indicated mild discomfort that subsided once the dressing was applied. Staff observed no other injuries to R46's legs. A skin assessment was completed from head to toe and noted a small healing abrasion to R46's left upper thigh. The physician and the resident's representative were notified.</p> <p>The Nurses Notes, dated 12/19/23 at 08:20 PM, documented R46 had a skin tear on her right lateral (outer side)calf. The area was 4.0 cm in length and the top layer of skin was peeled back and was in the shape of a triangle. Staff approximated the skin with three Steri-strips (adhesive closures) and a dry dressing R46 had no bleeding, swelling, or pain.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R46's EMR lacked any investigative notes regarding the incident. The facility was unable to provide evidence an investigation was completed.</p> <p>On 03/20/24 at 10:10 AM, observation revealed the resident sat in the living room in a wheelchair, dressed in capri pants and anti-slip socks. Continued observation revealed the resident had her right foot off the wheelchair foot pedal. R46's bilateral lower legs revealed no skin issues or open areas. R46 had a scar from a recent skin injury to her left calf and shin area.</p> <p>On 03/20/24 at 10:00 AM, Administrative Nurse D stated the medical records documented the resident had a skin tear on 10/25/23 and 12/19/23 but Administrative Nurse D stated administrative staff was unaware of how the injuries occurred. Administrative Nurse D verified the facility did not investigate to try to determine the cause of the injuries.</p> <p>The facility's Accident and Incidents-Investigating and Reporting policy, dated July 2017, documented that all accidents or incidents involving residents, employees, visitors, and vendors occurring on the facility premises shall be investigated and reported to the administrator. The nurse supervisor, charge nurse, or supervisor would promptly initiate and document an investigation of the accident or incident. The following data would be included on the Report of Incident or Accident form: The nature of the injury or illness and the circumstances surrounding the accident or incident; the name of the witness and their accounts of the accident or incident; any corrective actions taken. The nurse supervisor, charge nurse, department director, or supervisor would complete a Report of Incident or Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. The director of nursing services shall ensure that the administrator receives a copy of the Report of Incident or Accident form for each occurrence. The report would be reviewed by the safety committee for trends related to accidents or safety hazards in the facility and to analyze individual resident vulnerabilities.</p> <p>The facility failed to investigate R46's two injuries of unknown origin to rule out possible abuse or neglect. This placed R46 at risk for unidentified and ongoing abuse or neglect.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360</p> <p>The facility had a census of 85 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to develop comprehensive care plans for Resident (R)31, R77, and for R29. This placed the residents at risk for impaired care due to uncommunicated care needs.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Electronic Medical Record (EMR) for R31 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), and hypertension (high blood pressure). <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R31 had severely impaired cognition and required substantial/maximum assistance for toileting, dressing, personal hygiene, partial/moderate assistance with transfers, and mobility. R31 had no functional limitations, had one fall with injury since admission, received insulin, and antianxiety (class of medications that calm and relax people), and antidepressant (class of medications used to treat mood disorders) medication daily.</p> <p>R31's Fall Risk Assessments, dated 01/18/24 and 01/22/24 documented R31 was at risk for falls.</p> <p>R31's Care Plan, dated 01/18/24 documented R31 had diabetes mellitus but lacked any interventions or direction to staff on how to monitor for side effects from medications, signs and symptoms of hypoglycemia (lesser than normal amount of glucose in the blood) or hyperglycemia (greater than normal amount of glucose in the blood), and how to manage his diabetes. The care plan further documented R31 used a wheelchair for mobility. The plan directed staff to assess R31 for falls and distract him from wandering; R31 required assistance for ambulation. The care plan lacked interventions to prevent falls.</p> <p>The Physician's Order, dated 01/19/24, directed staff to administer Jardiance (improves blood sugar levels), 10 milligrams (mg) by mouth daily for diabetes mellitus type 2.</p> <p>The Physician's Order, dated 01/18/24, directed staff to obtain a blood sugar fasting, before meals, and at bedtime; and notify the physician if the blood sugar was below 60 milligrams (mg) per deciliter (dL) or above 250 mg/dL. This order was discontinued on 02/19/24.</p> <p>The Physician's Order, dated 01/28/24, directed staff to administer Lantus (insulin), 10 Units (U), subcutaneous (beneath the skin), at bedtime for diabetes mellitus type 2. This medication was discontinued on 02/07/24.</p> <p>The Treatment Administration Record (TAR), dated January 2024, documented 21 times out of 93 opportunities R31 had blood sugars outside the ordered parameters, and the physician was not notified.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The TAR dated January 2024, documented 22 times out of 56 opportunities R31 had blood sugars outside of ordered parameters and the physician was not notified.</p> <p>The Fall Investigation, dated 01/22/24 at 06:19 AM, documented R31 fell in the bathroom and obtained a bump and laceration (cut) to the back of his head. The report documented R31 was confused, had a gait imbalance, and forgot to use his call light. Staff reminded him to wear nonskid socks.</p> <p>The Nurse's Notes, dated 02/02/24 at 01:28 PM, documented R31 fell in the bathroom when get got up unattended. The noted documented R31 had on nonskid socks but did not use his call light. The staff reminded him to call for assistance.</p> <p>On 03/18/24 at 09:36 AM, observation revealed R31 propelled himself into his room, stood up from his wheelchair, and transferred himself to his bed.</p> <p>On 03/18/24 at 12:49 PM, observation revealed R31 independently ambulated out in the hallway and staff quickly ran to assist him back to his room.</p> <p>On 03/20/24 at 09:00 AM, observation revealed R31 sat in his wheelchair by the nurse's station.</p> <p>On 03/18/24 at 08:45 AM, Administrative Nurse D stated the care plan for R31's diabetes and falls should have been completed when the care plan was developed and implemented fall interventions.</p> <p>The facility's Care Planning-Interdisciplinary Team policy, dated 03/22, documented the team was responsible for the development of resident care plans. The care plan is comprehensive, person-centered, and based on the resident assessments and developed by the interdisciplinary team, and the family and resident were encouraged to participate in the development and revision of the resident's care plan.</p> <p>The facility failed to develop a comprehensive care plan for R31 with preventative measures for falls and for interventions or directions to staff on how to manage his diabetes. This placed the resident at risk for impaired care due to uncommunicated care needs.</p> <p>- R77's Electronic Medical Record (EMR) for R77 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), epilepsy (brain disorder characterized by repeated seizures), and diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin).</p> <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R77 had moderately impaired cognition. R77 required extensive assistance from two staff for transfers and extensive assistance from one staff for bed mobility, dressing, toileting, and personal hygiene. The MDS documented R77 felt down and depressed for 12 to 14 days during the observation period; R77 had no behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Quarterly MDS, dated [DATE], documented R77 had moderately impaired cognition. R77 required partial to moderate assistance with toileting, dressing, and personal hygiene. R77 required supervision with transfers, and he rejected care daily.</p> <p>R77's Care Plan, dated 01/18/24, initiated on 05/30/23, directed staff to administer medications as ordered, keep a consistent routine, and monitor changes in cognition. The plan directed staff to cue, reorient, and supervise R77 as needed. The update, dated 03/11/24, documented R77 urinated on the floor in his room and directed staff to assist the resident in developing more appropriate methods of coping. The plan directed staff to assist the resident in expressing his feelings appropriately, providing positive interactions, and discussing behaviors. The care plan lacked direction to staff regarding R77's mood and verbalizations of wanting to die.</p> <p>The Physician's Order, dated 05/28/23, directed staff to administer sertraline (an antidepressant medication), 25 milligrams (mg) by mouth daily for depression. The medication was discontinued on 01/03/24.</p> <p>The Nurse's Note, dated 06/11/23 at 04:38 PM, documented R77 kicked a staff member in the stomach and scratched another staff member on her side while they tried to reposition R77 and transfer him to his wheelchair after a fall. The note further documented staff notified Administrative Nurse D and a call was placed to a Geri-Psych hospital but there were no beds available. Staff were directed to work in pairs with R77. The EMR lacked evidence of follow-up with the Geri-Psych hospital for placement after the incident.</p> <p>The Nurse's Note, dated 08/04/23 at 06:07 AM, documented R77 refused all care during the shift.</p> <p>The Nurse's Note, dated 11/13/23 at 05:48 PM, documented R77 stated he wanted to die but did not have a plan to kill himself. Staff were directed to place R77 on 15-minute checks and continue to monitor.</p> <p>The Nurse's Note, dated 11/20/23 at 05:57 PM, documented R77 was sitting outside his room with his coat thrown on the floor. R77 stated he threw his coat on the floor because he was leaving. The note recorded all R77's clothes were on the floor.</p> <p>The Nurse's Note, dated 11/21/23 at 11:01 AM, documented R77 refused his medication and stated he wanted to have a seizure and die. R77 further stated that he wanted to get a gun and shoot everyone there. Staff attempted to reeducate R77 on appropriate behavior and asked if he would speak with a behavioral health nurse but R77 refused, and the physician was notified.</p> <p>The Nurse's Note, dated 01/08/24 at 07:10 PM, documented R77 demanded a blanket, screamed, and grabbed at the Certified Nurse Aide (CNA).</p> <p>The Nurse's Note, dated 02/23/24 at 04:05 AM, documented R77 stated he did not want to be there anymore, and he did not want to live on. R77 asked staff if they would send him to the hospital if he threw himself out of his wheelchair. R77 stated he would be happier if he lived under a bridge.</p> <p>The Nurse's Note, dated 02/24/24 at 06:12 PM, documented R77 took his mattress off the bed twice. Staff offered a psychiatric evaluation but R77 declined.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurse's Note, dated 03/09/24 at 10:35 AM, documented R77 urinated on the floor in his room and then stated he did it because he could.</p> <p>The Nurse's Note, dated 03/09/24 at 04:51 PM, documented R77 stated he was on a hunger strike because he wanted to die, R77 refused incontinence briefs and continued to urinate all over his room to make staff mad.</p> <p>The Nurse's Note, dated 03/11/24 at 11:03 AM, documented paperwork was faxed to a Geri-Psych hospital for possible admission.</p> <p>The Nurse's Note, dated 03/12/24 at 05:44 AM, documented R77 complained of pain but refused pain medication and stated, I am not taking that, I want to die, don't you understand that?</p> <p>The Nurse's Note, dated 03/12/24 at 12:15 PM, documented R77 continued to refuse medications and stated, I want to die but did not have a plan for self-harm.</p> <p>The Nurse's Note, dated 03/17/24 at 07:30 AM, documented R77 stated staff paralyzed him with medication. R77 said he wanted to die and R77's physician directed staff to place the resident on 15-minute suicide checks. At 02:37 PM, the physician came to the facility to check on R77, and at 06:00 PM, directed staff to check on R77 hourly.</p> <p>On 03/14/24 at 12:30 PM, observation revealed R77 on his bed with his head hung down. When asked about his life before his admission to the facility, R77 stated that he was struck by lightning and had to be resuscitated. R77 stated he wished he had not been resuscitated because he wanted to die. R77 made several statements that he wanted to die and said he would talk to someone about his feelings.</p> <p>On 03/14/24 at 12:40 PM, Social Service X stated R77 had not been struck by lightning, but he often told people that and stated that R77 liked to be in control. When informed of R77's statements regarding wanting to die, Social Service X stated that the Geri Psych hospital did not accept R77 as a patient due to R77's payor source. Social Service X went on to say there were no plans to seek other alternatives for R77 relating to his mood and desire to die. Social Service X stated that R77 was asked to see a therapist, but the resident refused. Social Service X stated she was able to get R77 to sign a consent to see a therapist and said she would try to contact R77's representative to inform him of the consent.</p> <p>On 03/18/24 at 09:01 AM, CNA O stated R77 had behaviors. CNA O said R77 would urinate on the floor and scream at staff; staff had to redirect him. CNA O further stated that she would tell the nurse when R77 had behaviors.</p> <p>On 03/20/24 at 09:30 AM, Licensed Nurse (LN) G stated there was a notice posted at the nurse's station since 03/15/24 that noted if R77 mentioned he wanted to die, staff were to place him on 15-minute safety checks and contact the physician if he refused his medications or fell. LN G further stated that R77 did not like to use his call light and said R77 would put himself on the floor when he had behaviors. LN G stated R77 did not participate in activities but would come out to eat in the dining room at times.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 09:45 AM, Administrative Nurse D stated she did not know what happened the previous weekend when R77 was placed on suicide watch but went on to say she knew R77 often made statements that he wanted to die. Administrative Nurse D stated she did not know why the facility had not tried other interventions for R77 when he declined to talk to a therapist. Administrative Nurse D stated the physician was aware of R77's refusals of medications and provided information to support that as many of R77's medications were discontinued.</p> <p>On 03/20/24 at 11:22 AM, Social Services X verified there were no care-planned interventions for R77's mood. Social Services X said she did not know why the nursing staff had not implemented 15-minute safety checks when R77 expressed that he wanted to die.</p> <p>The facility's Care Planning-Interdisciplinary Team policy, dated 03/22, documented the team was responsible for the development of resident care plans. The care plan is comprehensive, person-centered, and based on the resident assessments and developed by the interdisciplinary team, and the family and resident were encouraged to participate in the development and revision of the resident's care plan.</p> <p>The facility failed to develop a care plan for dementia care and services for R77 who had behaviors and made multiple statements that he wanted to die. This placed the resident at risk for impaired care due to uncommunicated care needs.</p> <p>- R29's Electronic Medical Record (EMR) documented R29 was admitted to the facility on [DATE] with diagnoses of neuromuscular dysfunction of the bladder (lacks bladder control due to brain, spinal cord, or nerve problems), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and pneumonia (inflammation of the lungs).</p> <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R29 had no behaviors. The MDS section on the assessment of activities of daily living and tobacco use was incomplete.</p> <p>R29's Care Plan for smoking, dated 03/05/24, four months after admission, directed staff to conduct a Smoking Safety Evaluation on admission and as needed (PRN). The plan directed staff to educate the resident on the facility's tobacco and smoking policy and orient R29 to smoking times and procedures. Staff were to ensure R29's eyeglasses were on. The 03/12/24 care plan update stated the resident required supervision while smoking and directed staff to utilize a cigarette holder and smoking apron for R29.</p> <p>The Admission Assessment, dated 11/29/23, stated R29 did not smoke.</p> <p>The Nurse Progress Note, dated 12/31/23 at 03:17 PM, documented R29 informed the nurse that he needed a Band-Aid for his middle finger on his right hand because he burned it while smoking two days ago due to no feeling in his fingers. The nurse noted the burn to his middle finger was healing and she applied ointment along with a Band-Aid. The note stated the nurse notified the physician's office and no new orders were received.</p> <p>The Smoking Assessment, dated 03/05/24, documented R29 smoked cigarettes daily and could independently light smoking materials safely. The assessment stated R29 followed policy and had no unsafe behavior related to smoking. The assessment documented R29 was safe to smoke unsupervised.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurse Progress Note, dated 03/12/24 at 10:50 AM, documented that staff reported R29 had burned his finger while smoking recently and noted R29 had a small circular scab on the top of his middle finger. R29 stated he did not feel when his cigarettes burned down and touched his skin. Staff educated the resident on safety precautions when smoking and he agreed to use a cigarette extender when smoking. The note stated the wound to his finger was cleansed and triple antibiotic ointment (TAO) was applied. Staff notified the physician.</p> <p>The Weekly Skin Assessment, dated 03/12/24 and 3/14/24 lacked information regarding the burn on R29's middle finger.</p> <p>The Smoking Safety Assessment, dated 03/14/24, documented R29 had burned skin, clothing, and furniture. The resident required supervision and a fire-resistant apron while smoking.</p> <p>On 03/18/24 at 03:03 PM, observation revealed R29 sat in his wheelchair outside, smoking with staff present. He wore a smoking apron.</p> <p>On 03/13/24 at 07:46 AM, R29 stated staff stayed with him while he smoked.</p> <p>On 03/18/24 at 01:35 PM, Administrative Nurse D verified no further assessment of skin after R29 burned his fingers smoking. Administrative Nurse D verified staff did not assess R29 for safe smoking practices after staff documented R29 burned his fingers smoking on 12/31/23.</p> <p>On 03/18/24 at 02:27 PM, Licensed Nurse (LN) G verified staff should have performed a smoking assessment when R29 started smoking at the facility. He stated the facility was in the process of getting an adapter for his cigarettes and staff always accompanied residents when they went out to smoke. LN G stated he expected to see the burned fingers on the skin assessment.</p> <p>The facility's Smoking Policy, dated 2017, stated the resident would be evaluated on admission to determine if he or she was a smoker, the ability to smoke safely with or without supervision, and concerns would be noted on the care plan.</p> <p>The facility's Comprehensive Person-Centered Care Plan policy, dated 2022, stated the comprehensive care plan would be developed within seven days of the MDS and no more than 21 days after admission. The care plan interventions would be derived from a thorough analysis of information gathered and chosen after careful consideration of the resident's problem areas, their causes, and relevant clinical decision-making.</p> <p>The facility failed to initiate a comprehensive care plan R29 for smoking when R29 began smoking at the facility and immediately after a smoking-related incident. This placed R29 at risk for unsafe smoking related to uncommunicated care needs.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768</p> <p>The facility had a census of 85 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to review and revise the care plan with interventions to address Resident (R) 30's pain and R46's skin tears. This deficient practice placed R30 and R46 for impaired care due to uncommunicated care needs.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R30's Electronic Medical Record (EMR) documented diagnoses of alcohol dependence, chronic pain in the right shoulder, and dorsalgia (physical discomfort occurring anywhere on the spine or back). <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R30 had no rejection of care behavior. The MDS documented R30 had no range of motion (ROM) impairment, used a wheelchair, and required partial moderate assistance for bathing. The MDS documented R30 received scheduled and as-needed (PRN) pain management but no non-medication pain relief for almost constant severe pain which interfered with his sleep and activities. R30 received opioid (narcotic) medication during the observation period.</p> <p>R30's Care Plan dated 01/08/24, lacked staff direction for non-medication pain relief measures.</p> <p>The Nurse Progress Note, dated 12/25/23 at 04:06 PM, stated R30 received PRN pain medications three times that shift, but the resident reported his pain never ended.</p> <p>R30's Medication Administration Record (MAR) documented staff administered his oxycodone (narcotic pain medication) up to six times in 24 hours.</p> <p>The Nurse Progress Note, dated 02/29/24 at 01:56 AM, stated R30's pain was increasing or staying the same, without relief. The note documented other possible relief measures that should be implemented. R30 watched the clock and went out and sat by the medication cart looking at the nurse. The note stated R30 would not ask for any medication but would become more and more upset if the nurse did not get him his medication and R30 would not be distracted.</p> <p>On 03/13/24 at 09:54 AM, observation revealed R30 lay in bed in a dark room. He stated he had constant pain in his right shoulder and hip from fractures due to falls when he was working. He stated he received oxycodone, but the pain control was not good. R30 stated staff have not offered heat or cold therapy or alternative pain interventions.</p> <p>On 03/18/24 at 02:12 PM, Licensed Nurse (LN) G stated other non-medication pain relief interventions could include a restorative program if the resident allowed. LN G said R30's pain level never strayed from a 10 (zero to 10 pain scale where zero is no pain and 10 is the worst pain imaginable). LN G stated the physician would not schedule pain medication for R30.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 09:27 AM, Administrative Nurse D stated staff should review the care plan to implement other alternatives to reduce pain such as offering a warm pack or checking with the activity department for aromatherapy or music to attempt to relieve R30's pain, and then document the attempts.</p> <p>The facility's Care Planning policy, dated 2022, stated the staff would encourage the resident and/or their family to participate in the development and revision of the care plan.</p> <p>The facility failed to review and revise the care plan for R30's pain management, placing R30 at risk for impaired care due to uncommunicated care needs.</p> <p>27168</p> <p>- R46's Electronic Medical Record (EMR) documented the resident had diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety.</p> <p>R46's Quarterly Minimum Data Set (MDS) dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) of three indicating severely impaired cognition. The MDS recorded the resident was dependent on staff for most activities of daily living (ADLs). The MDS recorded the resident required substantial to maximum staff assistance with all transfers and used a wheelchair for mobility.</p> <p>The Fall Risk Assessment, dated 10/04/23, recorded a score of 13.0 which indicated at risk for falls.</p> <p>R46's Care Plan, dated 11/07/23, directed staff to utilize a pressure-reducing mattress and cushion to the wheelchair, and fold the back or remove the wheelchair leg rest before transfer. The plan directed staff to keep R46's skin clean and dry. The care plan instructed staff to provide substantial to maximum assistance with toilet hygiene, rolling left to right, sitting to lying, and lying to sitting position. The care plan documented the resident needed a safe environment with even floors free from spills and or clutter, glare-free light, and a working and reachable call light. The care plan instructed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. The care plan lacked evidence interventions were added to prevent further skin injuries after a skin tear on 12/19/23.</p> <p>The Nurses Note, dated 10/25/23 at 10:44 AM, documented R46 had a large skin tear to her right lower extremity that was bleeding. There was a skin flap present, and the flap covered the entire tear. R45 had an area that measured 9.4 centimeters (cm) by 2.0 cm. Staff cleansed the area and the skin flap was approximated, and a dressing was applied. R46's behavior indicated mild discomfort that subsided once the dressing was applied. Staff observed no other injuries to R46's legs. A skin assessment was completed from head to toe and noted a small healing abrasion to R46's left upper thigh. The physician and the resident's representative were notified.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurses Notes, dated 12/19/23 at 08:20 PM, documented R46 was noted to have a skin tear on her right lateral calf, and the top layer of skin was peeled back. The area was 4.0 cm in length and the top layer of skin peeled back and was in the shape of a triangle. Staff approximated the skin with three Steri strips (adhesive closures) and a dry dressing applied. Staff then elevated R46's feet with pillows and a wedge. No bleeding, swelling, or pain was noted.</p> <p>R46's EMR lacked any investigative notes regarding the incident including witness statements, root cause, or investigation.</p> <p>On 03/20/24 at 10:10 AM, observation revealed the resident sat in the living room in a wheelchair, dressed in capri pants and anti-slip socks. Continued observation revealed the resident had her right foot off the wheelchair foot pedal. R46's bilateral lower legs revealed no skin issues or open areas; however, she had a scar from a recent skin injury to her left calf and shin area.</p> <p>On 03/20/24 at 10:00 AM, Administrative Nurse D stated the medical records documented the resident had a skin tear on 10/25/23 and 12/19/23 but Administrative Nurse D was unaware of how the injuries occurred. Administrative Nurse D verified the facility did not investigate when the incidents occurred.</p> <p>The Care Planning policy, dated March 2022, documented the facility's interdisciplinary team would develop the resident's care plan. The comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team. The interdisciplinary team consists of the resident physician, registered nurse, and nurse assistant responsible for the resident, a member of the food and nutrition services, the resident and the resident's representative, other staff as appropriate or necessary to meet the needs of the resident, or as requested by the resident.</p> <p>The facility failed to review or revise the care plan with interventions that addressed the causative factor to prevent further skin tears for R46, placing R46 at risk for injuries related to uncommunicated care needs.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168</p> <p>The facility had a census of 85 residents. The sample included 18 residents with five residents reviewed for activities of daily living (ADLs). Based on observation, record review, and interview the facility failed to provide necessary services to maintain good personal hygiene including bathing for Resident (R) 4, R41, and R30. This placed the residents at risk for impaired health and decreased psychosocial well-being.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R4's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heartbeat). <p>R4's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R4 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS recorded R4 required substantial to maximum assistance of staff for most activities of daily living including bathing.</p> <p>R4's Care Plan, dated 11/09/23 indicated R4 required extensive staff assistance with transfers and ADL care.</p> <p>R4's bathing/shower task documentation revealed the resident was scheduled to have a shower or bath twice a week on Tuesdays and Fridays.</p> <p>The January 2024 bathing report documented the resident refused showers/baths on the following dates with no follow-up or documentation the resident was reapproached later or on another shift.</p> <p>01/23/24</p> <p>01/26/24</p> <p>01/30/24</p> <p>The January 2024 report lacked evidence the resident received a shower or bath that month.</p> <p>The February 2024 bathing report documented the resident received a shower on the following days:</p> <p>02/23/24</p> <p>02/027/24</p> <p>The resident refused showers/baths on the following dates with no follow-up or documentation the resident was reapproached later or on another shift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>02/02/24</p> <p>02/06/24</p> <p>02/13/24</p> <p>02/17/24</p> <p>The March 2024 bathing report documented the resident refused showers/baths on the following dates with no follow-up or documentation the resident was reapproached later or on another shift.</p> <p>03/01/24</p> <p>03/08/24</p> <p>03/12/24</p> <p>03/15/24</p> <p>On 03/14/24 at 08:35 AM, observation revealed R4 lying in bed dressed in street clothes. Her hair was uncombed and appeared greasy.</p> <p>On 03/20/24 at 09:15 AM, Administrative Nurse D verified the residents had scheduled bath/shower days twice a week. Administrative Nurse D said the aides documented bathing in the EMR but the facility did use shower sheets as well. Administrative Nurse D verified the resident's EMR and shower sheets lacked evidence the resident received her two showers a week.</p> <p>The facility's Bath, Shower and Tub policy, dated February 2018, documented the facility would ensure a resident was clean, provide comfort to the resident, and observe the condition of the resident's skin. The staff would document the date and time the shower or tub bath was performed, the name of the individual who assisted, all assessment data obtained during the shower or tub bath, the resident's refusal of the procedure, the reason why, and the intervention taken, including the signature and title of the person recording the data. The policy recorded the staff would notify the supervisor if the resident refused the shower or tub bath.</p> <p>The facility failed to provide the necessary care and bathing services for R4, placing the resident at risk for impaired health.</p> <p>- R41's Electronic Medical Record (EMR) recorded diagnoses of bilateral above the knee amputations (surgical removal of a body part), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory, and confusion) and anxiety.</p> <p>R41's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R41 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS recorded R41 was dependent on staff for most activities of daily living including bathing.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R41's Care Plan, dated 11/07/23 indicated R41 required extensive assistance from one staff with transfers and ADL care.</p> <p>R41's bathing and shower task documentation revealed the resident was scheduled to have a shower or bath twice a week on Mondays and Thursdays.</p> <p>The January 2024 bathing report documented the resident refused showers or baths on the following days with no follow-up or documentation the resident was reapproached later or on another shift:</p> <p>01/11/24</p> <p>01/18/24</p> <p>01/25/24</p> <p>The January 2024 bathing report documented the resident received a shower on the following days:</p> <p>01/01/24</p> <p>01/04/24</p> <p>01/08/24</p> <p>01/15/24</p> <p>01/28/24 (13 days with no shower or bath)</p> <p>The February 2024 bathing report documented the resident refused showers or baths on the following days with no follow-up or documentation the resident was reapproached later or on another shift:</p> <p>02/08/24</p> <p>02/15/24</p> <p>02/19/24</p> <p>02/22/24</p> <p>02/29/24</p> <p>The February 2024 bathing report documented the resident received a shower on the following days:</p> <p>02/04/24</p> <p>02/25/24 (20 days with no shower or bath)</p> <p>The March bathing report documented the resident refused showers or baths on the following days with no follow-up or documentation the resident was reapproached later or on another shift:</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>03/05/24</p> <p>03/17/24</p> <p>03/14/24</p> <p>03/18/24 (21 days with no shower or bath)</p> <p>The March 2024 bathing report documented the resident had not received a shower in March.</p> <p>On 03/13/24 at 11:50 AM, observation revealed R41 sat in a wheelchair in the dining room eating lunch. The resident had a long gray beard that appeared uncombed.</p> <p>On 03/20/24 at 09:15 AM, Administrative Nurse D verified the residents had scheduled bath/shower days twice a week. Administrative Nurse D said the aides documented bathing in the EMR but the facility did use shower sheets as well. Administrative Nurse D verified the resident's EMR and shower sheets lacked evidence the resident received his two showers a week.</p> <p>The facility's Bath, Shower and Tub policy, dated February 2018, documented the facility would ensure a resident was clean, provide comfort to the resident, and observe the condition of the resident's skin. The staff would document the date and time the shower or tub bath was performed, the name of the individual who assisted, all assessment data obtained during the shower or tub bath, the resident's refusal of the procedure, the reason why, and the intervention taken, including the signature and title of the person recording the data. The policy recorded the staff would notify the supervisor if the resident refused the shower or tub-bath</p> <p>The facility failed to provide the necessary care and bathing services for R41, placing the resident at risk for impaired health and well-being.</p> <p>26768</p> <p>- R30's Electronic Medical Record (EMR) documented diagnoses of chronic pain in the right shoulder and dorsalgia (physical discomfort occurring anywhere on the spine or back).</p> <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R30 had no rejection of care behavior. The MDS documented R30 had no range of motion (ROM) impairment, used a wheelchair, and required partial moderate assistance for bathing.</p> <p>R30's Care Plan dated 01/08/24 stated R30 had a functional ability deficit related to weakness, limited mobility, and pain. The care plan directed staff to provide a sponge bath when a full bath or shower cannot be tolerated; R30 had a history of consistently refusing to shower, but staff were to continue to offer and encourage the resident to take showers. R30 required partial to moderate assistance with showers or bathing.</p> <p>R30's February and March 2024 shower paperwork documented all showers had been refused and staff documented they asked him several times. The nurse signed the papers.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R30's clinical record, including the shower sheets, lacked evidence the staff reapproached the resident at different times or offered alternative hygiene options when R30 refused bathing.</p> <p>On 03/13/24 at 09:54 AM, observation revealed R30 lay in bed, and the room was dark. R30 stated showers had to be taken before 02:00 PM, or staff would not provide one until his next scheduled shower day. He stated he had diarrhea and stomach cramps at times and missed his showers quite often due to that.</p> <p>On 03/18/24 at 01:49 PM, Certified Nurse Aide (CNA) O stated she did not offer showers as the facility had shower aides.</p> <p>On 03/18/24 at 10:30 AM, CNA P (shower aide) stated the male residents were offered showers on Mondays and Thursdays. She stated the other CNAs were to provide showers in the evenings or weekends. She stated she had not offered moist bath wipes to the resident.</p> <p>On 03/18/24 at 10:30 AM, CNA Q, a shower aide, stated R30 would agree to take his shower, and then refuse. She stated the shower aide shift ended at 02:00 PM. CNA Q said the shower aides informed the regular staff of any showers that still needed to be done and the information was to be passed on to evening shift staff.</p> <p>On 03/18/24 at 212 PM, Licensed Nurse (LN) G stated staff should offer bed baths, bath wipes, or shampoo caps to residents for alternative bathing options.</p> <p>On 03/20/24 at 09:27 AM, Administrative Nurse D stated staff should offer a warm pack of bath wipes if residents refused a shower. Administrative Nurse D verified there was no documentation that alternative bathing options were offered by staff.</p> <p>The facility's Bath, Shower and Tub policy, dated February 2018, documented the facility would ensure a resident was clean, provide comfort to the resident, and observe the condition of the resident's skin. The staff would document the date and time the shower or tub bath was performed, the name of the individual who assisted, all assessment data obtained during the shower or tub bath, the resident's refusal of the procedure, the reason why, and the intervention taken, including the signature and title of the person recording the data. The policy recorded the staff would notify the supervisor if the resident refused the shower or tub bath.</p> <p>The facility failed to provide the necessary care and bathing services for R30 including offering alternatives or evening bathing opportunities. This placed the resident at risk for impaired health.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768</p> <p>The facility had a census of 85 residents. The sample included 18 residents with five reviewed for accidents. Based on observation, interview, and record review the facility failed to ensure an environment free from preventable accident hazards for Resident (R) 29 who burned his fingers his fingers while smoking. The facility further failed to assess R41 for the ability to smoke safely and failed to provide interventions to prevent injuries and falls for R46 and R31. These deficient practices placed the residents at risk for injuries related to accidents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R29's Electronic Medical Record (EMR) documented R29 admitted to the facility 11/29/23 with diagnoses of neuromuscular dysfunction of bladder (lacks bladder control due to brain, spinal cord, or nerve problems), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and pneumonia (inflammation of the lungs). <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R29 had no behaviors. The MDS section on assessment of activities of daily living and tobacco use was incomplete.</p> <p>R29's Care Plan for smoking, dated 03/05/24, four months after admission, directed staff to conduct a Smoking Safety Evaluation on admission and as needed (PRN). The plan directed staff to educate the resident on the facility's tobacco and smoking policy and orient R29 to smoking times and procedures. Staff were to ensure R29's eyeglasses were on. The 03/12/24 care plan update stated the resident required supervision while smoking and directed staff to utilize a cigarette holder and smoking apron for R29.</p> <p>The Admission Assessment, dated 11/29/23, stated R29 did not smoke.</p> <p>The Nurse Progress Note, dated 12/31/23 at 03:17 PM, documented R29 informed the nurse that he needed a Band-Aid for his middle finger on his right hand because he burned it while smoking two days ago due to no feeling in his fingers. The nurse noted the burn to his middle finger was healing and she applied ointment along with a Band-Aid. The note stated the nurse notified the physician's office and no new orders were received.</p> <p>The Smoking Assessment, dated 03/05/24, documented R29 smoked cigarettes daily and could independently light smoking materials safely. The assessment stated R29 followed policy and had no unsafe or hazardous behavior related to smoking. The assessment documented R29 was safe to smoke unsupervised.</p> <p>The Nurse Progress Note, dated 03/12/24 at 10:50 AM, documented staff reported R29 had burned his finger while smoking recently and noted R29 had a small circular scab to the top of his middle finger. R29 stated he did not feel when his cigarettes burned down and touched his skin. Staff educated the resident on safety precautions when smoking and he agreed to use a cigarette extender when smoking. The note stated the wound to his finger was cleansed and triple antibiotic ointment (TAO) applied. Staff notified the physician.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Weekly Skin Assessment, dated 03/12/24 and 3/14/24 lacked information regarding the burn on R29's middle finger.</p> <p>The Smoking Safety Assessment, dated 03/14/24, documented R29 had burned skin. The resident required supervision and a fire-resistant apron while smoking.</p> <p>On 03/18/24 at 03:03 PM, observation revealed R29 sat in his wheelchair outside, smoking with staff present. He wore a smoking apron.</p> <p>On 03/13/24 at 07:46 AM, R29 stated staff stay with him while he smoked.</p> <p>On 03/18/24 at 01:35 PM, Administrative Nurse D verified no further assessment of skin after R29 burned his fingers smoking. Administrative Nurse D verified staff did not assess R29 for safe smoking practices after staff documented R29 burned his fingers smoking on 12/31/23.</p> <p>On 03/18/24 at 02:27 PM, Licensed Nurse (LN) G verified staff should have performed a smoking assessment when R29 started smoking at the facility. He stated the facility was in the process of getting an adapter for his cigarettes and staff always accompanied residents when they went out to smoke. LN G stated he expected to see the burned fingers on the skin assessment.</p> <p>The facility's Smoking Policy, dated 2017, stated prior to and upon admission, residents would be informed of the facility smoking policy, including designated areas, and the extent to which the facility could accommodate their smoking preferences. The policy stated the resident would be evaluated on admission to determine if he or she was a smoker, the current level of tobacco consumption, method, and the ability to smoke safely with or without supervision. The resident's ability to smoke safely would be re-evaluated quarterly, with a significant change, and as determined by staff. Any smoking related privileges, restrictions, and concerns would be noted on the care plan and all personnel caring for the resident would be alerted to those issues.</p> <p>The facility failed to prevent smoking related accidents for R29 after he burned his fingers while smoking. Staff failed to assess R29 for safety while smoking or implement preventive actions to prevent future burns. This placed R29 at risk for injuries and pain related to burns.</p> <p>27168</p> <p>- R41's Electronic Medical Record (EMR) recorded diagnoses of bilateral above the knee amputations (surgical removal of a body part), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory, confusion) and anxiety.</p> <p>R41's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R41 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS recorded R41 was dependent on staff for most activities of daily living (ADL) including bathing. The MDS documented R41 used a wheelchair for mobility. The MDS lacked documentation that the resident smoked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R41's Care Plan, dated 11/07/23 indicated R41 required extensive assistance from one staff with transfers and ADL care. The care plan documented R41 smoked, and the facility would keep smoking materials in a secured location. The plan directed staff instructed R41 about the facility policy on smoking, location, times, and safety concerns.</p> <p>The Smoking Safe Risk assessment dated [DATE], documented the resident had awareness and orientation including the ability to understand the facility's safe smoking policy. The assessment documented no concern regarding the potential for causing injury to self or others from smoking in unauthorized areas or careless use of smoking material. The assessment recorded the resident had minimal problems with mobility and manual dexterity and required supervision with smoking. The assessment documented the resident smoked one pack of cigarettes a day.</p> <p>R41's clinical record lacked evidence of further assessment for safe smoking practices and policy since the 11/13/21 assessment.</p> <p>On 3/14/24 at 2:45 PM observation revealed R41 dressed in street clothes sitting in a wheelchair in front of the South nurse's station. R41 awaited staff to take him out to the patio to smoke. Continued observation revealed staff got the resident's cigarettes and lighters from the locked nurses' medication room and took R41 outside. Staff provided R41 with his cigarettes and assisted him with lighting the cigarettes.</p> <p>On 03/20/24 at 10:00 AM, Administrative Nurse D verified that R41 smoked. Administrative Nurse D stated R41 would go outside approximately four times a day at designated times with staff present. Administrative Nurse D verified the last facility smoking assessment that was completed for the resident was on 11/13/21 and said the facility should complete one at least every quarter.</p> <p>The Smoking Assessment policy, dated July 2017, documented the facility would establish and maintain safe resident smoking practices. The resident would be evaluated on admission to determine if he or she is a smoker. If the resident is a smoker, the evaluation would include the current level of tobacco consumption, method of tobacco consumption, desire to quit smoking, and ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). The staff shall consult with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. The resident's ability to smoke would be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff.</p> <p>The facility failed to promote a safe environment free from accident hazards for R41 when the facility failed to assess R41's ability to smoke safely. This placed the resident at risk for preventable accidents and related injury.</p> <p>- R46's Electronic Medical Record (EMR) documented the resident had diagnoses of congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid,) diabetes mellitus Type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin,) osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), dementia (progressive mental disorder characterized by failing memory, confusion), and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R46's Quarterly Minimum Data Set (MDS) dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) of three indicating severely impaired cognition. The MDS recorded the resident was dependent on staff for most activities of daily living (ADLs). The MDS recorded the resident required substantial to maximum staff assistance with all transfers and used a wheelchair for mobility.</p> <p>The Fall Risk Assessment, dated 10/04/23, recorded a score of 13.0 which indicated a risk for falls.</p> <p>R46's Care Plan, dated 11/07/23, directed staff to utilize a pressure-reducing mattress and cushion to the wheelchair, and fold the back or remove the wheelchair leg rest before transfer. The plan directed staff to keep R46's skin clean and dry. The care plan instructed staff to provide substantial to maximum assistance with toilet hygiene, rolling left to right, sitting to lying, and lying to sitting position. The care plan documented the resident needed a safe environment with even floors free from spills and or clutter, glare-free light, and a working and reachable call light. The care plan instructed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface.</p> <p>The Nurses Note, dated 10/25/23 at 10:44 AM, documented that R46 had a large skin tear to her right lower extremity that was bleeding. There was a skin flap present, and the flap covered the entire tear. R46 had an area that measured 9.4 centimeters (cm) by 2.0 cm. Staff cleansed the area and the skin flap was approximated, and a dressing was applied. R46's behavior indicated mild discomfort that subsided once the dressing was applied. Staff observed no other injuries to R46's legs. A skin assessment was completed from head to toe and noted a small healing abrasion to R46's left upper thigh. The physician and the resident's representative were notified.</p> <p>The Nurses Notes, dated 12/19/23 at 08:20 PM, documented that R46 had a skin tear on her right lateral calf. The area was 4.0 cm in length and the top layer of skin peeled back and was in the shape of a triangle. Staff approximated the skin with three Steri-strips (adhesive closures) and a dry dressing applied. Staff then elevated R46's feet with pillows and a wedge. No bleeding, swelling, or pain was noted.</p> <p>R46's EMR lacked any investigative notes regarding the incident including witness statements, root cause, or investigation.</p> <p>On 03/20/24 at 10:10 AM, observation revealed the resident sat in the living room in a wheelchair, dressed in capri pants and anti-slip socks. Continued observation revealed the resident had her right foot off the wheelchair foot pedal. R46's bilateral lower legs revealed no skin issues or open areas. She had a scar from a recent skin injury to her left calf and shin area.</p> <p>On 03/20/24 at 10:00 AM, Administrative Nurse D stated the medical records documented the resident had a skin tear on 10/25/23 and 12/19/23 but Administrative Nurse D was unaware of how the injuries occurred. Administrative Nurse D verified the facility did not investigate, how the injuries incidents occurred.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Accident and Incidents-Investigating and Reporting policy, dated July 2017, documented that all accidents or incidents involving residents, employees, visitors, and vendors occurring on the facility premises shall be investigated and reported to the administrator. The nurse supervisor, charge nurse, or supervisor would promptly initiate and document an investigation of the accident or incident. The following data would be included on the Report of Incident or Accident form:</p> <p>The date and time the accident or incident took place.</p> <p>The nature of the injury or illness.</p> <p>The circumstances surrounding the accident or incident.</p> <p>Where the accident or incident took place.</p> <p>The name of the witness and their accounts of the accident or incident.</p> <p>The injured person's account of the accident or incident.</p> <p>The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions.</p> <p>The date and time the injured person's family was notified and by whom.</p> <p>The condition of the injured person, including his or her vital signs.</p> <p>The disposition of the injured.</p> <p>Any corrective action is taken.</p> <p>Follow-up information.</p> <p>Other pertinent data as necessary or required, and</p> <p>The signature and title of the person completing the report.</p> <p>The nurse supervisor, charge nurse, department director, or supervisor would complete a Report of Incident or Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident.</p> <p>The director of nursing services shall ensure that the administrator receives a copy of the Report of Incident or Accident form for each occurrence.</p> <p>The Incident or Accident report would be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze and individual resident vulnerabilities.</p> <p>The facility failed to thoroughly investigate causative factors and develop and implement interventions to reduce or prevent accidents resulting in skin tears for R46, which placed her at increased risk for further injuries.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>32360</p> <p>- The Electronic Medical Record (EMR) for R31 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), and hypertension (high blood pressure).</p> <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R31 had severely impaired cognition. R31 required substantial/maximum assistance for toileting, dressing, and personal hygiene. R31 required partial/moderate assistance with transfers and mobility. R31 had no functional limitations and had one fall with injury since admission.</p> <p>R31's Fall Risk Assessments, dated 01/18/24 and 01/22/24 documented R31 was at risk for falls.</p> <p>R31's Care Plan, dated 01/18/24, documented R31 used a wheelchair for mobility. The plan directed staff to assess R31 for falls and distract him from wandering; R31 required assistance for ambulation. The care plan lacked interventions to prevent falls.</p> <p>The Fall Investigation, dated 01/22/24 at 06:19 AM, documented R31 fell in the bathroom and obtained a bump the size of a golf ball and a laceration (cut) to the back of his head. The report documented R31 was confused, had a gait imbalance, and forgot to use his call light. Staff reminded him to wear nonskid socks.</p> <p>The Nurse's Notes, dated 02/02/24 at 01:28 PM, documented R31 fell in the bathroom when get got up unattended. The noted documented R31 had on nonskid socks but did not use his call light. The staff reminded him to call for assistance.</p> <p>On 03/18/24 at 09:36 AM, observation revealed R31 propelled himself into his room, stood up from his wheelchair, and transferred himself to his bed.</p> <p>On 03/18/24 at 12:49 PM, observation revealed R31 independently ambulated out in the hallway and staff quickly ran to assist him back to his room.</p> <p>On 03/18/24 at 08:45 AM, Administrative Nurse D stated there was not a fall investigation completed for R31's fall on 02/02/24 and verified the resident did not have care-planned interventions in place to prevent falls.</p> <p>On 03/18/24 at 10:00 AM, Certified Nurse Aide (CNA) O stated R31 liked to transfer without staff assistance and staff encouraged him to call for assistance.</p> <p>On 03/20/24 at 09:30 AM, Licensed Nurse (LN) G stated R31 required one staff assistance for transfers and was a stand-by assist for ambulation. LN G stated R31 fell because he did not use his call light to wait for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Falls and Fall Risk, Managing policy, dated 03/18, documented the staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. The staff, with the input of the attending physician, would implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). If interventions have been successful in preventing falling, staff would continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention had been resolved. If the resident continued to fall, staff would re-evaluate the situation and whether it was appropriate to continue or change current interventions. As needed, the attending physician would help the staff reconsider possible causes that may not previously have been identified.</p> <p>The facility failed to identify and implement resident-centered interventions to prevent falls for cognitively impaired R31. This placed the resident at risk for further falls.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768</p> <p>The facility had a census of 85 residents. The sample included 18 residents with five reviewed for urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) or urinary tract infection (UTI-an infection in any part of the urinary system). Based on observation, interview, and record review the facility failed to provide care and services to prevent potential infection of the urinary system for Resident (R) 29 and R17 during care for their urinary catheters and failed to promote dignity with a privacy bag. This deficient practice placed R29 and R17 at risk for urinary infections and other catheter-related complications.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R29's Electronic Medical Record (EMR) documented diagnoses of neuromuscular dysfunction of the bladder (lacks of bladder control due to brain, spinal cord, or nerve problems), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), urinary tract infection (UTI-an infection in any part of the urinary system) and pneumonia (inflammation of the lungs). <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R29 had no behaviors and the current assessment of activities of daily living was incomplete. The MDS documented R29 had a urinary catheter and received antibiotic medication.</p> <p>R29's Catheter Care Plan, dated 02/01/24, directed staff to apply a catheter strap to prevent pulling on the catheter, adjust as needed, and observe skin for indentations. The plan directed staff to keep the Foley tubing free of kinks and avoid tension on the urinary meatus. Staff were to change the Foley catheter and drainage bag per physician orders and empty the urine drainage bag every shift; notify the charge nurse if less than 300 cubic centimeters (CC) of urine in eight hours. The plan directed staff to maintain the drainage bag below the level of the bladder and provide catheter care with soap and water every shift; monitor for signs of UTI. Staff were to perform bladder assessments upon admission, quarterly, and as needed (PRN).</p> <p>The Physician Order, dated 12/01/23, directed staff to provide urinary catheter care every shift and document output.</p> <p>The Progress Note, dated 01/01/24 at 10:32 PM, documented R29 was having bloody urine and it was noted that there was no output in the Foley bag or the tubing. The note stated R29 had an order to change the indwelling catheter on that date. Staff attempted to change the urinary catheter and had no urine return. While removing the catheter, blood began to flow so staff notified the on-call provider and were advised to send R29 to the emergency room . R29 was transferred to via emergency services (EMS) and returned from the emergency room (ER) later by EMS. A new catheter was placed at the ER.</p> <p>R29's Urine Culture, dated 01/09/24, documented R29 had an infection.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurse Progress Note, dated 01/28/24 at 02:00 PM, stated the physician saw R29 and ordered R29 sent to the hospital due to low-grade fever in the last few evenings to rule out UTI.</p> <p>On 03/13/24 at 10:23 AM, observation revealed R29 lay in bed, and his urinary catheter bag, lacking a privacy cover, was on the floor.</p> <p>On 03/18/24 at 01:22 PM, observation revealed Certified Nurse Aide (CNA) N emptied R29's urinary catheter. She set a measuring canister on the bare, visibly soiled floor. She then wiped the catheter bag port with a moist wipe (no disinfectant) and began to drain the urine. During draining, the port end touched inside of the used canister, which was dated 03/16/24. After draining the bag, she used a moist wipe (with no disinfectant) on the port, rinsed the measuring canister with water, then wiped the inside and outside of it. CNA N did not place the drainage bag in a privacy bag.</p> <p>On 03/13/24 at 07:46 AM, R29 stated the urinary catheter bag was on the floor frequently.</p> <p>On 03/13/24 at 10:23 AM, Certified Medication Aide (CMA) T verified the catheter bag should not be allowed on the floor and stated R29 finished antibiotic treatments for a UTI recently.</p> <p>On 03/18/24 at 01:30 PM, Licensed Nurse (LN) G stated staff should not allow the urinary catheter bag to lie on the floor and said staff should put the catheter bag in a privacy bag. He stated staff should place a clean barrier on the floor when draining the urine collection bag. LN G said staff should use a cleaning wipe or alcohol pad on the port and confirmed staff were to change the measuring canister weekly and PRN.</p> <p>On 03/18/24 at 01:35 PM, Administrative Nurse D verified staff should not allow the urinary catheter bag to lie on the floor and said staff should put the catheter bag in a privacy bag. Administrative Nurse D said staff should place a clean barrier on the floor when draining the catheter bag and use an alcohol wipe on the port. Administrative Nurse D confirmed staff was to change the measuring canister weekly and PRN.</p> <p>The facility's Catheter Care, Urinary policy, dated 2014, directed staff to maintain an accurate record of the daily output, keep the tubing free of kinks, and always position the drainage bag lower than the bladder. Staff were to maintain a clean technique when handling or manipulating the catheter, tubing, or drainage bag. Staff was to ensure the catheter tubing and drainage bag were kept off the floor, empty the drainage bag at least every eight hours, and prevent contact of the drainage spigot with the nonsterile collection canister.</p> <p>The facility failed to ensure appropriate care and services for R29's urinary catheter care bag when staff failed to use appropriate infection control practices when storing and handling the drainage bag and did not place it in a privacy bag. This placed the resident at risk for catheter related complications.</p> <p>- R17's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), obstructive and reflux uropathy (disorder of the urinary tract due to obstructed urinary flow), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and urinary tract infection (UTI-an infection in any part of the urinary system).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Tonganoxie Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 East Street Tonganoxie, KS 66086	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented R17 required staff assistance for dressing, bathing, and toileting. R17 had no rejection of care behaviors. The MDS documented R17 had a urinary catheter and urostomy.</p> <p>R17's Care Plan, dated 02/14/24, stated the resident had an indwelling catheter related to a neurogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and a right nephrostomy tube (an artificial opening created between the kidney and the skin which allows for the urinary diversion). The care plan stated the resident had a 16 French catheter with a 10 cubic centimeter (cc) balloon and directed staff to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. The care plan directed staff to check tubing for kinks during care each shift, monitor and document intake and output as per facility policy, monitor and document for pain or discomfort due to the catheter, and monitor for signs of UTI.</p> <p>The Physician Order, dated 01/23/24, directed staff to provide a Foley catheter, size 16 French, 10 milliliter (ml) balloon, for neurogenic bladder due to kidney failure.</p> <p>The Physician Note, dated 03/11/24, stated the urine culture showed Escherichia coli E-coli:(bacteria commonly found in the lower intestine that had a potential for causing infections in the urinary tract with inadequate incontinence care) and Proteus mirabilis (bacteria). The physician documented R17 had a neurogenic bladder with an indwelling catheter, and he ordered antibiotic medication intravenously (IV-administered directly into the bloodstream via a vein) every 12 hours for 10 days.</p> <p>On 03/13/24 at 03:47 PM, and 03/14/24 at 07:32 AM, an observation revealed R17 in bed with a urinary catheter drainage bag hung on the side of her bed with no privacy bag. R17's urine was visible from the hall.</p> <p>On 03/14/24 at 02:45 PM, observation revealed R17 in bed with a urinary catheter drainage bag hung on the side of her bed with no privacy bag; urine was visible from the hall. Observation revealed Certified Medication Aide (CMA) S placed a measuring container on R17's bare floor, provided urinary catheter care, and then emptied the Foley bag of 800 milliliters (ml) of yellow urine. She did not disinfect the port. CMA S emptied and rinsed the measuring canister and did not change gloves or wash her hands before she handled and emptied the nephrostomy bag of 50 ml yellow urine. CMA S did not disinfect the nephrostomy port.</p> <p>On 03/18/24 at 11:28 AM, observation revealed Certified Nurse Aide (CNA) M donned gloves, set a measuring container (dated 3/10) on R17's bare floor, and emptied urine from the Foley bag. Without changing gloves or washing her hands, CNA M emptied the nephrostomy bag. CNA M rinsed the measuring canister with water and wiped the inside and out with a paper towel. She did not place the catheter bag into a privacy bag before leaving the room.</p> <p>On 03/18/24 at 12:20 PM, Administrative Nurse E stated staff should place the Foley bag in a privacy bag. Administrative Nurse E said staff should not place the canister on the bare floor, and staff should change gloves and wash hands between emptying the Foley and the nephrostomy bags. She stated staff should use an alcohol wipe on the port.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 09:27 AM, Administrative Nurse D verified staff should place the Foley bag in a privacy bag and staff should not place the canister on the bare floor. Administrative Nurse D said staff should change gloves and wash hands between the Foley and the nephrostomy bags and should use an alcohol wipe on the port.</p> <p>The facility's Catheter Care, Urinary policy, dated 2014, directed staff to maintain an accurate record of the daily output, keep the tubing free of kinks, and always position the drainage bag lower than the bladder. Staff were to maintain a clean technique when handling or manipulating the catheter, tubing, or drainage bag. Staff were to ensure the catheter tubing and drainage bag were kept off the floor, empty the drainage bag at least every eight hours, and prevent contact of the drainage spigot with the nonsterile collection container.</p> <p>The facility failed to provide appropriate catheter care and services practices when handling the urinary catheter bag. This placed R17 at increased risk for infection and other catheter-related complications.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768</p> <p>The facility had a census of 85 residents. The sample included 18 residents with one reviewed for pain. Based on observation, interview, and record review the facility failed to provide non-medicinal pain relief measures and promote effective pain management for Resident (R) 30, who experienced almost constant severe pain. This deficient practice placed R30 at risk for ongoing severe pain and impaired quality of life.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R30's Electronic Medical Record (EMR) documented diagnoses of alcohol dependence, chronic pain in the right shoulder, and dorsalgia (physical discomfort occurring anywhere on the spine or back). <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R30- had no rejection of care behavior. The MDS documented R30 had no range of motion (ROM) impairment, used a wheelchair, and required partial moderate assistance for bathing. The MDS documented R30 received scheduled and as-needed (PRN) pain management but no non-medication pain relief for almost constant severe pain which interfered with his sleep and activities. R30 received opioid (narcotic) medication during the observation period.</p> <p>R30's Care Plan dated 01/08/24 stated R30 had a functional ability deficit related to weakness, limited mobility, and pain with a history of pathological (broken bone caused by disease) spinal fracture. The care plan stated R30 had chronic pain and directed staff to administer analgesia (pain relief) per orders and give one-half hour before treatments or care. The care plan directed staff to evaluate the effectiveness of pain interventions, review for compliance, alleviating of symptoms, dosing schedules, resident satisfaction with results, impact on functional ability, and impact on cognition. The care plan directed staff to notify the physician if interventions were unsuccessful or if the resident's complaint was a significant change from his past experiences of pain. The plan directed staff to observe and report changes in usual routine, sleep patterns, decrease in functional abilities, withdrawal, or resistance to care related to pain or discomfort. The care plan lacked staff direction for non-medication pain relief measures.</p> <p>The Physician Order, dated 10/03/2023, directed staff to administer Tylenol 1000 milligrams (mg), three times per day for pain.</p> <p>The Physician Order, dated 12/30/23, directed staff to administer oxycodone (narcotic for moderate to severe pain) 10 mg every four hours PRN.</p> <p>The Nurse Progress Note, dated 12/25/23 at 04:06 PM, stated R30 received PRN pain medications three times that shift, but the resident reported his pain never ended.</p> <p>R30's Medication Administration Record (MAR) documented staff administered his oxycodone up to six times in 24 hours.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurse Progress Note, dated 02/29/24 at 01:56 AM, stated R30's pain was increasing or staying the same, without relief. The note documented other possible relief measures should be implemented. R30 watched the clock and went out and sat by the medication cart looking at the nurse. The note stated R30 would not ask for any medication but would become more and more upset if the nurse did not get him his medication and R30 would not be distracted.</p> <p>R30's EMR lacked evidence staff consistently offered and attempted non-pharmacological interventions to treat pain.</p> <p>On 03/13/24 at 09:54 AM, observation revealed R30 lay in bed in a dark room. He stated he had constant pain in his right shoulder and hip from fractures due to falls when he was working. He stated he received oxycodone, but the pain control was not good. R30 stated staff have not offered heat or cold therapy or alternative pain interventions.</p> <p>On 03/18/24 at 01:49 PM, Certified Nurse Aide (CNA) O stated the resident always says he is in pain, so she tells the nurse because he says he only wants a pain pill.</p> <p>On 03/18/24 at 02:12 PM, Licensed Nurse (LN) G stated other non-medication pain relief interventions could include a restorative program if the resident allowed. LN G said R30's pain level never strayed from a 10 (zero to 10 pain scale where zero is no pain and 10 is the worst pain imaginable). LN G stated the physician would not schedule pain medication for R30.</p> <p>On 03/20/24 at 09:27 AM, Administrative Nurse D stated staff should offer a warm pack or check with the activity department for aromatherapy or music to attempt to relieve R30's pain and then document the attempts.</p> <p>The facility's Pain-Clinical Protocol policy, dated 2018, stated the physician and staff would review diagnoses and conditions that commonly cause pain to identify residents who have pain or are at risk of having pain. The review would include any treatments the resident was currently receiving for pain, including complementary and non-medication treatments. The staff and physician would evaluate how pain was affecting the resident's mood, activities of daily living, sleep, and quality of life, as well as how pain may be contributing to complications such as social isolation. With input from the resident, the physician and staff would establish goals for pain treatment and the physician would order appropriate non-medication and medication interventions to address the resident's pain. Staff would provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain. If there were more than occasional analgesic requests, the physician would consider changing to regular administration of at least one analgesic with another for PRN use for breakthrough pain, increasing the regular dose, and or adding non-medication measures.</p> <p>The facility failed to provide non-medicinal pain relief measures and promote effective pain management for R30, who experienced almost constant severe pain. This deficient practice placed R30 at risk for ongoing severe pain and impaired quality of life.</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360</p> <p>The facility had a census of 85 residents. The sample included 18 residents with two reviewed for dementia (progressive mental deterioration characterized by confusion and memory failure) care. Based on observation, record review, and interview, the facility failed to provide the necessary dementia care and services to attain or maintain the highest level of practicable physical, mental, and psychosocial well-being for Resident (R)26 and R77. This placed the residents at risk for decreased quality of life.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Electronic Medical Record (EMR) for R26 recorded diagnoses of mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgment, and make decisions), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R26 had severely impaired cognition and required extensive assistance from one staff for bed mobility, dressing, toileting, and limited assistance from one staff for transfers and personal hygiene. R26 had no falls.</p> <p>The Quarterly MDS, dated [DATE], documented R26 had severely impaired cognition, and required substantial/maximum assistance for toileting, mobility, transfers, toileting, and lower dressing. The MDS documented R26 had no behaviors.</p> <p>R26's Care Plan, dated 03/12/24, documented R26 had cognitive impairment with poor safety awareness and decision-making abilities. The care plan lacked further mention of her cognitive impairment including interventions related to her behaviors.</p> <p>The Physician's Order, dated 04/20/23, directed staff to administer Lexapro (an antidepressant medication used to treat mood disorders), 10 milligrams (mg) by mouth daily for depression. The medication was discontinued on 11/06/23.</p> <p>The Physician's Order, dated 06/28/23, directed staff to administer Ativan (an antianxiety medication used to calm and relax people), 0.5 mg by mouth every four hours as needed for agitation. The medication was discontinued on 08/03/23.</p> <p>The Physician's Order, dated 11/07/23, directed staff to administer Celexa, (an antidepressant) medication 5 mg by mouth daily for depression. The medication was discontinued on 12/05/23.</p> <p>The Physician's Order, dated 12/08/23, directed staff to administer Seroquel (antipsychotic- medications used to treat major mental conditions that cause a break from reality), 25 mg by mouth every four hours as needed for anxiety. The medication was discontinued on 12/08/23.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurse's Note, dated 06/28/23 at 09:30 PM, documented R26 displayed aggressiveness. R26 hit, bit, kicked, and pushed furniture around. R26 tried to run over people with her wheelchair. The note further documented R26 hollered and screamed at staff. R26 tried to pull her roommate out of bed. Staff tried to put R26 to bed without success. Staff received an order for Ativan, but R26 refused.</p> <p>R26's clinical record lacked evidence the facility investigated the incident to identify potential triggers or causative factors related to R26's incident with her roommate. R26's clinical record lacked evidence the facility identified and implemented interventions related to R26's behavior.</p> <p>On 03/13/24 at 11:03 AM, observation revealed R26 sat in her wheelchair and propelled herself out of a resident's room. R26 attempted to go into another resident's room, and she was told to not come in. Staff redirected her.</p> <p>On 03/14/24 at 02:45 PM, Administrative Nurse D stated she had not investigated the incident between R26 and her roommate and should have followed up on the incident.</p> <p>On 03/18/24 at 01:20 PM, Certified Nurse Aide (CNA) O stated R26 did not have a lot of behaviors. CNA O said R26 hollered out a lot but did not get physical.</p> <p>On 03/20/24 at 09:30 AM, Licensed Nurse (LN) G stated that he had not seen any behaviors with R26 and said the resident usually stayed around the nurse's station. LN G did not know if R26 had behaviors at night.</p> <p>The facility's Behavioral Health Services policy, undated, documented the facility would provide and residents would receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The policy further documented that behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care.</p> <p>The facility failed to provide person-centered interventions to address agitation and behaviors for R26, who tried to pull her roommate out of bed when she was agitated. This placed the residents at risk for abuse and decreased quality of life.</p> <p>- R77's Electronic Medical Record (EMR) for R77 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), epilepsy (brain disorder characterized by repeated seizures), and diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin).</p> <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R77 had moderately impaired cognition. R77 required extensive assistance from two staff for transfers and extensive assistance from one staff for bed mobility, dressing, toileting, and personal hygiene. The MDS documented R77 felt down and depressed for 12 to 14 days during the observation period; R77 had no behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Quarterly MDS, dated [DATE], documented R77 had moderately impaired cognition. R77 required partial to moderate assistance with toileting, dressing, and personal hygiene. R77 required supervision with transfers, and he rejected care daily.</p> <p>R77's Care Plan, dated 01/18/24, initiated on 05/30/23, directed staff to administer medications as ordered, keep a consistent routine, and monitor changes in cognition. The plan directed staff to cue, reorient, and supervise R77 as needed. The update, dated 03/11/24, documented R77 urinated on the floor in his room and directed staff to assist the resident in developing more appropriate methods of coping. The plan directed staff to assist the resident in expressing his feelings appropriately, provide positive interactions, and discuss behaviors. The care plan lacked direction to staff regarding R77's mood and verbalizations of wanting to die.</p> <p>The Physician's Order, dated 05/28/23, directed staff to administer sertraline (an antidepressant medication), 25 milligrams (mg) by mouth daily for depression. The medication was discontinued on 01/03/24.</p> <p>The Nurse's Note, dated 06/11/23 at 04:38 PM, documented R77 kicked a staff member in the stomach and scratched another staff member on her side while they tried to reposition R77 and transfer him to his wheelchair after a fall. The note further documented staff notified Administrative Nurse D and a call was placed to a Geri-Psych hospital but there were no beds available. Staff were directed to work in pairs with R77. The EMR lacked evidence of follow-up with the Geri-Psych hospital for placement after the incident.</p> <p>The Nurse's Note, dated 08/04/23 at 06:07 AM, documented R77 refused all care during the shift.</p> <p>The Nurse's Note, dated 11/13/23 at 05:48 PM, documented R77 stated he wanted to die but did not have a plan to kill himself. Staff were directed to place R77 on 15-minute checks and continue to monitor.</p> <p>The Nurse's Note, dated 11/20/23 at 05:57 PM, documented R77 sat outside his room with his coat thrown on the floor. R77 stated he threw his coat on the floor because he was leaving. The note recorded all R77's clothes were on the floor.</p> <p>The Nurse's Note, dated 11/21/23 at 11:01 AM, documented R77 refused his medication and stated he wanted to have a seizure and die. R77 further stated that he wanted to get a gun and shoot everyone there. Staff attempted to reeducate R77 on appropriate behavior and asked if he would speak with a behavioral health nurse but R77 refused, and the physician was notified.</p> <p>The Nurse's Note, dated 01/08/24 at 07:10 PM, documented R77 demanded a blanket, screamed, and grabbed at the Certified Nurse Aide (CNA).</p> <p>The Nurse's Note, dated 02/23/24 at 04:05 AM, documented R77 stated he did not want to be there anymore, and he did not want to live on. R77 asked staff if they would send him to the hospital if he threw himself out of his wheelchair. R77 stated he would be happier if he lived under a bridge.</p> <p>The Nurse's Note, dated 02/24/24 at 06:12 PM, documented R77 took his mattress off the bed twice. Staff offered a psychiatric evaluation but R77 declined.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Nurse's Note, dated 03/09/24 at 10:35 AM, documented R77 urinated on the floor in his room and then stated he did it because he could.</p> <p>The Nurse's Note, dated 03/09/24 at 04:51 PM, documented R77 stated he was on a hunger strike because he wanted to die, R77 refused incontinence briefs and continued to urinate all over his room to make staff mad.</p> <p>The Nurse's Note, dated 03/11/24 at 11:03 AM, documented paperwork was faxed to a Geri-Psych hospital for possible admission.</p> <p>The Nurse's Note, dated 03/12/24 at 05:44 AM, documented R77 complained of pain but refused pain medication and stated, I am not taking that, I want to die, don't you understand that?</p> <p>The Nurse's Note, dated 03/12/24 at 12:15 PM, documented R77 continued to refuse medications and stated, I want to die but did not have a plan for self-harm.</p> <p>The Nurse's Note, dated 03/17/24 at 07:30 AM, documented R77 stated staff paralyzed him with medication. R77 said he wanted to die and R77's physician directed staff to place the resident on 15-minute suicide checks. At 02:37 PM, the physician came to the facility to check on R77, and at 06:00 PM, directed staff to check on R77 hourly.</p> <p>On 03/14/24 at 12:30 PM, observation revealed R77 on his bed with his head hung down. When asked about his life before his admission to the facility, R77 stated that he was struck by lightning and had to be resuscitated. R77 stated he wished he had not been resuscitated because he wanted to die. R77 made several statements that he wanted to die and said he would talk to someone about his feelings.</p> <p>On 03/14/24 at 12:40 PM, Social Service X stated R77 had not been struck by lightning, but he often told people that and stated that R77 liked to be in control. When informed of R77's statements regarding wanting to die, Social Service X stated that the Geri Psych hospital did not accept R77 as a patient due to R77's payor source. Social Service X went on to say there were no plans to seek other alternatives for R77 relating to his mood and desire to die. Social Service X stated that R77 was asked to see a therapist, but the resident refused. Social Service X stated she was able to get R77 to sign a consent to see a therapist and said she would try to contact R77's representative to inform him of the consent.</p> <p>On 03/18/24 at 09:01 AM, CNA O stated R77 had behaviors. CNA O said R77 would urinate on the floor and scream at staff; staff had to redirect him. CNA O further stated that she would tell the nurse when R77 had behaviors.</p> <p>On 03/20/24 at 09:30 AM, Licensed Nurse (LN) G stated there was a notice posted at the nurse's station since 03/15/24 that noted if R77 mentioned he wanted to die, staff were to place him on 15-minute safety checks and contact the physician if he refused his medications or fell. LN G further stated that R77 did not like to use his call light and said R77 would put himself on the floor when he had behaviors. LN G stated R77 did not participate in activities but would come out to eat in the dining room at times.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Tonganoxie Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 East Street Tonganoxie, KS 66086	
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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 09:45 AM, Administrative Nurse D stated she did not know what happened the previous weekend when R77 was placed on suicide watch but went on to say she knew R77 often made statements that he wanted to die. Administrative Nurse D stated she did not know why the facility had not tried other interventions for R77 when he declined to talk to a therapist. Administrative Nurse D stated the physician was aware of R77's refusals of medications and provided information to support that as many of R77's medications were discontinued.</p> <p>On 03/20/24 at 11:22 AM, Social Services X verified there were no care-planned interventions for R77's mood. Social Services X said she did not know why the nursing staff had not implemented 15-minute safety checks when R77 expressed that he wanted to die.</p> <p>The facility's Behavioral Health Services policy, undated, documented the facility would provide and residents would receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. The policy further documented that behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care.</p> <p>The facility failed to provide person-centered interventions to address mood and behaviors for R77 who had dementia and made multiple statements that he wanted to die. This placed the resident at risk for abuse and decreased quality of life.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360</p> <p>The facility had a census of 85 residents. The sample included 18 residents, with eight reviewed for unnecessary medications. Based on observation, record review, and interview, the Consultant Pharmacist (CP) failed to identify and report medications administered outside of physician-ordered parameters for Resident (R) 15, R31, and R6 and failed to identify and report an inappropriate indication for Seroquel (an antipsychotic medication used to treat severe mental disorders) for R4. This placed the residents at risk for adverse side effects, physical decline, and unnecessary medications.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R15's Electronic Medical Record (EMR) recorded diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), hypotension (low blood pressure), and heart failure (a condition with low heart output and the body becomes congested with fluid). <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented R15 had moderately impaired cognition and required substantial/maximum assistance for toileting, showering, and personal hygiene. R15 required supervision for transfers. R15 did not ambulate. R15 was on dialysis (a procedure where impurities or wastes were removed from the blood). R15 received anticoagulant (decreases the blood's ability to clot) medication daily.</p> <p>R15's Medicare 5-Day MDS, dated [DATE], documented R15 had moderately impaired cognition and required supervision for ambulation and toileting. R15 was independent for mobility, and transfers, and was on dialysis. R15 received an anticoagulant and diuretic (medication to promote the formation and excretion of urine) medication daily.</p> <p>R15's Care Plan, dated 12/13/23, initiated on 09/25/23, directed staff to encourage adequate fluid intake and a healthy diet. Staff was to give medications as ordered, monitor for side effects, and obtain diagnostic work as ordered.</p> <p>The Physician's Order, dated 11/13/23, directed staff to administer midodrine (treats low blood pressure), 10 milligrams (mg), by mouth, three times a day and hold if his systolic blood pressure (SBP-the top number that measures the force the heart exerts on the walls of the arteries each time it beat) was greater than (>) 110 millimeters of mercury (mmHg). The medication was discontinued on 03/20/24.</p> <p>The Medication Administration Record (MAR), dated January 2024, documented 29 times out of 93 opportunities R15 received the midodrine medication when his blood pressure was above the ordered parameters.</p> <p>The Pharmacist Review dated 01/25/24 recommended the facility obtain hold parameters for metoprolol but lacked recommendations regarding staff not holding the midodrine medication when the blood pressures were out of parameter.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/14/24 at 07:32 AM, observation revealed R15 watched television in his room.</p> <p>On 03/14/24 at 11:15 AM, Administrative Nurse D stated the medications should have been held when they were out of parameters. Administrative Nurse D said the pharmacist sent a recommendation in February documenting the errors of the medications and a nurse provided education to the staff that made the errors.</p> <p>On 03/18/24, at 09:26 AM, Certified Medication Aide (CMA) R stated she received education regarding the medication error and when the medication should be held but she did not understand what the < or > symbols meant so she did not know for certain when to hold the medication.</p> <p>On 03/20/24 at 09:30 AM, Licensed Nurse (LN) G stated in a perfect world the CMA would tell him when the blood pressure was out of parameters but that did not always happen. LN G said when R15 went to dialysis, he looked at the vitals section in the EMR but not specifically in the MAR, so he would not know if R15's blood pressure was out of parameters for the medication.</p> <p>On 03/20/24 at 09:30 AM, Administrative Nurse D stated the pharmacist had notified the facility at the end of February that some errors were occurring with R15's blood pressure medication but had not mentioned anything prior.</p> <p>The facility's Medication Regimen Reviews policy, dated 05/19, documented the consultant pharmacist performed a medication regimen review (MRR) for every resident in the facility who received medication. The goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medications. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication-related problems, medication errors, and other irregularities, for example: incorrect medications, administration times, dosage forms, or other medication errors, including those related to documentation.</p> <p>The facility failed to ensure the CP identified and reported to the facility that staff were not holding blood pressure medication when the blood pressure was out of parameters. This placed the resident at risk for medication complications.</p> <p>- The Electronic Medical Record (EMR) for R31 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), and hypertension (high blood pressure).</p> <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R31 had severely impaired cognition and required substantial/maximum assistance for toileting, dressing, and personal hygiene. R31 required partial/moderate assistance with transfers and mobility. R31 received insulin (a hormone that lowers the level of glucose in the blood), antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders) medication daily.</p> <p>R31's Care Plan, dated 01/18/24 directed staff to administer R31's antidepressant and antianxiety medication as ordered, educate the resident and family about the risks of the medication, and monitor for adverse side effects. The care plan lacked any interventions or direction to staff on how to administer and monitor for side effects from medications related to hypertension.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Physician's Order, dated 01/19/24, directed staff to administer lisinopril (treats high blood pressure), 5 milligrams (mg), by mouth, daily and hold if his systolic blood pressure (SBP-the top number that measures the force the heart exerts on the walls of the arteries each time it beat) was less than (<) 110 millimeters of mercury (mmHg).</p> <p>R31's EMR lacked documentation the staff obtained R31's blood pressure before administering the lisinopril medication for 78 administrations since the start of the medication.</p> <p>The Pharmacist Review, dated 01/18/24 and 02/28/24, documented no recommendations.</p> <p>On 03/18/24 at 09:36 AM, observation revealed R31 propelled himself into his room, stood up from his wheelchair, and transferred himself to his bed.</p> <p>On 03/18/24 at 08:45 AM, Administrative Nurse D verified the staff had not obtained R31's blood pressure before the administration of R31's blood pressure medication and did not understand why the pharmacist had not identified this.</p> <p>The facility's Medication Regimen Reviews policy, dated 05/19, documented the consultant pharmacist performed a medication regimen review (MRR) for every resident in the facility who received medication. The goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medications. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication-related problems, medication errors, and other irregularities, for example: incorrect medications, administration times, dosage forms, or other medication errors, including those related to documentation.</p> <p>The facility failed to ensure the CP identified and reported that staff were not monitoring R31's blood pressure before the administration of a blood pressure medication as ordered. This placed the resident at risk for medication complications.</p> <p>26768</p> <p>- R6's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN-elevated blood pressure), and diabetes mellitus (DM-when the body cannot use glucose (sugar), not enough insulin is made, or the body cannot respond to the insulin).</p> <p>The 5-Day Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS documented R6 was independent for most activities of daily living. The MDS documented R6 received insulin (hormone that lowers the level of glucose in the blood), diuretic (medication to promote the formation and excretion of urine), and hypoglycemic medications (drugs used to decrease glucose levels in the blood) during the observation period.</p> <p>R6's Care Plan, dated 12/28/23, directed staff to administer medications as ordered and monitor for side effects and effectiveness.</p> <p>The Physician Orders, dated 12/27/23, directed staff to administer the following:</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Hydralazine (medication used to treat high blood pressure), 50 milligrams (mg), twice daily, for HTN. Hold (do not give) if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 110 millimeters of mercury (mm/Hg).</p> <p>Cozaar (medication used to treat high blood pressure) 25 mg twice daily for HTN. Hold if SBP is less than 110 mmHg.</p> <p>Metoprolol ER (extended-release medication used to treat high blood pressure) 100 mg, twice daily for HTN. Hold if SBP is less than 110 mmHg.</p> <p>R6's Medication Administration Record (MAR) documented R6's SBP was less than 110 mmHg on the following dates:</p> <p>February 2024 on 2/3, 2/4, 2/7, 2/9,2/14, 2/20, 2/21.</p> <p>March 2024 on 3/2, 3/6, 3/7, 3/8, and 3/9.</p> <p>R6's MAR for February and March 2024 documented that staff administered Hydralazine five times in February and March when the physician's order stated to hold it.</p> <p>R6's MAR for February and March 2024 documented that staff administered Cozaar eight times in February and March when the physician order stated to hold it.</p> <p>R6's MAR for February and March 2024 documented staff administered metoprolol five times in February and March 2024 when the physician order stated to hold it.</p> <p>The Physician Order, dated 01/29/24, directed staff to administer Humalog (fast-acting insulin), 25 units before meals for diabetes mellitus and hold if the finger stick blood sugar (FSBS) was less than 110 milligrams per deciliter (mg/dL).</p> <p>R6's MAR for February and March 2024 documented staff administered the Humalog when R6's FSBS was less than 110 mg/dL 10 times, on the following dates in February and March on 2/3, 2/7, 2/17, 2/20, 2/23, 2/25, 2/26, 2/27 and 3/10, 3/12.</p> <p>The Consultant Pharmacist Drug Regimen Review, dated 02/28/24 lacked notation that medications were administered when vital signs were less than physician-ordered parameters.</p> <p>On 03/20/24 at 08:45 AM, observation revealed Certified Medication Aide (CMA) RR administered medications to R6 including hydralazine 50 mg, Cozaar 25 mg, and metoprolol 100 mg. CMA RR obtained a blood pressure first with a wrist cuff. She stated R6's blood pressure was low, so she took it again and obtained a blood pressure of 83/32 mmHg and a pulse of 65 beats per minute. CMA RR held the Cozaar, metoprolol, and hydralazine.</p> <p>On 03/20/24 at 11:35 AM, Administrative Nurse D verified the CP had not noted the staff administration of blood pressure medications and insulin when the physician ordered it to be held.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's Medication Regimen Reviews policy, dated 05/19, documented the consultant pharmacist performed a medication regimen review (MRR) for every resident in the facility who received medication. The goal of the MRR was to promote positive outcomes while minimizing adverse consequences and potential risks associated with medications. The MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication-related problems, medication errors, and other irregularities, for example: incorrect medications, administration times, dosage forms, or other medication errors, including those related to documentation.</p> <p>The facility's CP failed to identify and report the administration of blood pressure medications and insulin when the physician ordered it to be held. This placed R6 at risk for adverse medication effects.</p> <p>27168</p> <p>- R4's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heartbeat).</p> <p>R4's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R4 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS recorded R4 required substantial to maximum assistance of staff for most activities of daily living including bathing. The MDS recorded the resident received antipsychotic medication during the observation period.</p> <p>The Psychotropic Drug Use Care Area Assessment (CAA), dated 08/03/23, recorded R4 had dementia, and was alert and able to make needs known. R4 had a history of depression and received medications for the diagnosis that were monitored monthly by the pharmacist.</p> <p>R4's Care Plan, dated 11/07/23 recorded that R4 received antipsychotic medication and staff monitored for side effects and effectiveness. The care plan documented the resident received a Black Box Warning (BBW-highest safety-related warning) medication and had nursing considerations that need to be monitored.</p> <p>The Physician's Order, initial order date 09/13/22, directed the staff to administer Seroquel (antipsychotic) 25 milligrams (mg), 12.5 mg tablet twice daily for a diagnosis of Alzheimer's.</p> <p>R4's EMR lacked a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued Seroquel use.</p> <p>The CP's monthly reviews for R4 on 04/26/23, 05/26/23, 06/28/23, 07/28/23, 08/28/23, 09/29/23, 10/27/23, 11/27/23, 12/21/23, 01/27/24, and 02/28/24 lacked a recommendation for an appropriate indication for the continued use of Seroquel. The CP's monthly review for R4 revealed on 08/28/23, the pharmacist documented the resident received Seroquel 12.5 mg and recommended that the physician consider a dose reduction; the physician declined.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 03/14/24 at 08:35 AM, observation revealed the resident lay in bed with the head of the bed elevated 45 degrees. Continued observation revealed Certified Medication Aide (CMA) RR administered the resident's morning medication which included Seroquel. R4 spit out the medication except for the Seroquel, Eliquis (blood thinner), and folic acid (vitamin).</p> <p>On 03/20/24 at 10:10 AM, Administrative Nurse D verified the resident received Seroquel with a diagnosis of Alzheimer's which was an inappropriate indication for the medication. Administrative Nurse D verified the pharmacist had sent monthly reviews to the facility for concerns.</p> <p>The facility's Pharmacist Services-Role of the Consulting Pharmacist dated April 2019 recorded the drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. The pharmacist would inform to the facility leadership about potential or actual problems related to any aspect of medications and pharmacy services, including medication irregularities, and pertinent resident-specific documentation in the medical record, as indicated.</p> <p>The facility failed to ensure the CP identified and reported the inappropriate indication for the continued use of Seroquel. This placed the resident at risk for unnecessary antipsychotic medication with side effects.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360</p> <p>The facility had a census of 85 residents. The sample included 18 residents, with eight reviewed for unnecessary medication. Based on observation, record review, and interview, the facility failed to notify the physician of blood sugars outside of ordered parameters for Resident (R) 31 and further failed to monitor R31's blood pressure before administration of medication for high blood pressure. The facility failed to hold blood pressure medication and insulin (medication that lowers the level of glucose [a type of sugar] in the blood) when the medication was out of the physician-ordered parameters for R6. This placed the residents at risk for adverse effects related to medication.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Electronic Medical Record (EMR) for R31 documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance, diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made, or the body cannot respond to the insulin), and hypertension (high blood pressure). <p>The Admission Minimum Data Set (MDS), dated [DATE], documented R31 had severely impaired cognition and required substantial/maximum assistance for toileting, dressing, personal hygiene, partial/moderate assistance with transfers, and mobility. R31 received insulin, antianxiety (a class of medications that calm and relax people), and antidepressant (a class of medications used to treat mood disorders) medication daily.</p> <p>R31's Care Plan, dated 01/18/24 documented R31 had diabetes mellitus but lacked any interventions or direction to staff on how to monitor for side effects from medications, signs and symptoms of hypoglycemia (lesser than normal amount of glucose in the blood) or hyperglycemia (greater than normal amount of glucose in the blood), and how to manage his diabetes. The care plan lacked any interventions or direction to staff on how to administer and monitor for side effects from medications related to hypertension.</p> <p>The Physician's Order, dated 01/18/24, directed staff to obtain a blood sugar fasting, before meals, and at bedtime; and notify the physician if the blood sugar was below 60 milligrams (mg) per deciliter (dL) or above 250 mg/dL. This order was discontinued on 02/19/24.</p> <p>The Physician's Order, dated 01/19/24, directed staff to administer Jardiance (improves blood sugar levels), 10 milligrams (mg) by mouth daily for diabetes mellitus type 2.</p> <p>The Physician's Order, dated 01/19/24, directed staff to administer lisinopril (treats high blood pressure), 5 mg by mouth daily; hold if his systolic blood pressure (SBP-the top number that measures the force the heart exerts on the walls of the arteries each time it beat) was less than (<) 110 millimeters of mercury (mmHg).</p> <p>The Physician's Order, dated 01/28/24, directed staff to administer Lantus (insulin), 10 Units (U), subcutaneous (beneath the skin), at bedtime for diabetes mellitus type 2. This medication was discontinued on 02/07/24.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R31's Treatment Administration Record (TAR), dated January 2024, documented 21 times out of 93 opportunities R31 had blood sugars outside the ordered parameters, and the physician was not notified as ordered.</p> <p>R31's TAR dated February 2024, documented 22 times out of 56 opportunities R31 had blood sugars outside of ordered parameters and the physician was not notified as ordered.</p> <p>R31's EMR lacked documentation the staff obtained R31's blood pressure before administering the lisinopril medication for 78 administrations since the start of the medication.</p> <p>On 03/20/24 at 09:00 AM, observation revealed R31 sat in his wheelchair by the nurse's station.</p> <p>On 03/18/24 at 08:45 AM, Administrative Nurse D stated the care plan for R31's diabetes should have been completed when the care plan was developed. Administrative Nurse D verified the blood sugars outside of the ordered parameters that were not reported to the physician. Administrative Nurse D verified the staff had not obtained R31's blood pressure before the administration of R31's blood pressure medication.</p> <p>On 03/20/24 at 09:30 AM, Licensed Nurse (LN) G stated that he had only started working at the facility in February and said the physician should be notified when a blood sugar was out of the parameters.</p> <p>The facility's Diabetes-Clinical Protocol, dated 02/20 documented that the Physician would order desired parameters for monitoring and reporting information related to blood sugar management. The staff would incorporate such parameters into the Medication Administration Record and care plan and staff would identify and report issues that may affect, or be affected by, a patient's diabetes and diabetes management such as foot infections, skin ulceration, increased thirst, or hypoglycemia.</p> <p>The facility's Administering Medications policy, dated 2019, stated medications would be administered by prescriber orders. Medication errors would be documented, reported, and reviewed by the Quality Assurance Program Improvement Committee. The individual administering the medication would check the label three times to ensure the right resident, right medications, right dosage, right time, and right method of administration before giving the medication. The vital sign information would be checked or verified for each resident before administering medications. If a drug was withheld the individual would initial and circle the MAR space provided for that drug and dose.</p> <p>The facility failed to notify the physician of R31's out-of-parameter blood sugars as ordered and failed to monitor blood pressure before administration of medications. This placed the resident at risk for adverse medication effects.</p> <p>26768</p> <p>- R6's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN-elevated blood pressure), and diabetes mellitus (DM-when the body cannot use glucose (sugar), not enough insulin is made, or the body cannot respond to the insulin).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Tonganoxie Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 East Street Tonganoxie, KS 66086	
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 5-Day Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition. The MDS documented R6 was independent for most activities of daily living. The MDS documented R6 received insulin (hormone that lowers the level of glucose in the blood), diuretic (medication to promote the formation and excretion of urine), and hypoglycemic medications (drugs used to decrease glucose levels in the blood) during the observation period.</p> <p>R6's Care Plan, dated 12/28/23, directed staff to administer medications as ordered and monitor for side effects and effectiveness.</p> <p>The Physician Orders, dated 12/27/23, directed staff to administer the following:</p> <p>Hydralazine (medication used to treat high blood pressure), 50 milligrams (mg), twice daily, for HTN. Hold (do not give) if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 110 millimeters of mercury (mm/Hg).</p> <p>Cozaar (medication used to treat high blood pressure) 25 mg twice daily for HTN. Hold if SBP is less than 110 mmHg.</p> <p>Metoprolol ER (extended-release medication used to treat high blood pressure) 100 mg, twice daily for HTN. Hold if SBP is less than 110 mmHg.</p> <p>R6's Medication Administration Record (MAR) documented R6's SBP was less than 110 mmHg on the following dates:</p> <p>February 2024 on 2/3, 2/4, 2/7, 2/9,2/14, 2/20, 2/21.</p> <p>March 2024 on 3/2, 3/6, 3/7, 3/8, and 3/9.</p> <p>R6's MAR for February and March 2024 documented that staff administered Hydralazine five times in February and March when the physician's order stated to hold it.</p> <p>R6's MAR for February and March 2024 documented that staff administered Cozaar eight times in February and March when the physician order stated to hold it.</p> <p>R6's MAR for February and March 2024 documented staff administered metoprolol five times in February and March 2024 when the physician order stated to hold it.</p> <p>The Physician Order, dated 01/29/24, directed staff to administer Humalog (fast-acting insulin), 25 units before meals for diabetes mellitus and hold if the finger stick blood sugar (FSBS) was less than 110 milligrams per deciliter (mg/dL).</p> <p>R6's MAR for February and March 2024 documented staff administered the Humalog when R6's FSBS was less than 110 mg/dL 10 times, on the following dates in February and March on 2/3, 2/7, 2/17, 2/20, 2/23, 2/25, 2/26, 2/27 and 3/10, 3/12.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 08:45 AM, observation revealed Certified Medication Aide (CMA) RR administered medications to R6 including hydralazine 50 mg, Cozaar 25 mg, and metoprolol 100 mg. CMA RR obtained a blood pressure first with a wrist cuff. She stated R6's blood pressure was low, so she took it again and obtained a blood pressure of 83/32 mmHg and a pulse of 65 beats per minute. CMA RR held the Cozaar, metoprolol, and hydralazine.</p> <p>On 03/20/24 at 11:35 AM, Administrative Nurse D verified staff should have held the insulin as ordered when the blood sugar was less than 110 mg/dL. Administrative Nurse D also verified staff should have held the three blood pressure medications as ordered when R6's SBP was less than 110 mmHg.</p> <p>The facility's Administering Medications policy, dated 2019, stated medications would be administered by prescriber orders. Medication errors would be documented, reported, and reviewed by the Quality Assurance Program Improvement Committee. The individual administering the medication would check the label three times to ensure the right resident, right medications, right dosage, right time, and right method of administration before giving the medication. The vital sign information would be checked or verified for each resident before administering medications. If a drug was withheld the individual would initial and circle the MAR space provided for that drug and dose.</p> <p>The facility failed to administer or hold medications as the physician ordered, placing R6 at risk for unintended medication adverse effects.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27168</p> <p>The facility had a census of 85 residents. The sample included 18 residents, with eight reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of Resident (R)4's antipsychotic (a medication used to treat any major mental disorder characterized by a gross impairment testing) medication. This placed R4 at risk for unintended effects related to psychotropic (alters mood or thought) drug medications.</p> <p>Findings include:</p> <ul style="list-style-type: none"> - R4's Electronic Medical Record (EMR) recorded diagnoses of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), major depressive disorder (major mood disorder which causes persistent feelings of sadness), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and atrial fibrillation (rapid, irregular heartbeat). <p>R4's Quarterly Minimum Data Set (MDS), dated [DATE] recorded R4 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. The MDS recorded R4 required substantial to maximum assistance of staff for most activities of daily living including bathing. The MDS recorded the resident received antipsychotic medication during the observation period.</p> <p>The Psychotropic Drug Use Care Area Assessment (CAA), dated 08/03/23, recorded R4 had dementia, and was alert and able to make needs known. R4 had a history of depression and received medications for the diagnosis that were monitored monthly by the pharmacist.</p> <p>R4's Care Plan, dated 11/07/23 recorded R4 received antipsychotic medication and staff monitored for side effects and effectiveness. The care plan documented the resident received a Black Box Warning (BBW-highest safety-related warning) medication and had nursing considerations that need to be monitored.</p> <p>The Physician's Order, initial order date 09/13/22, directed the staff to administer Seroquel (antipsychotic) 25 milligrams (mg), 12.5 mg tablet twice daily for a diagnosis of Alzheimer's.</p> <p>R4's EMR lacked a documented physician rationale which included unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued Seroquel use.</p> <p>On 03/14/24 at 08:35 AM, observation revealed the resident lay in bed with the head of the bed elevated 45 degrees. Continued observation revealed Certified Medication Aide (CMA) RR administered the resident's morning medication which included Seroquel. R4 spit out the medication except for the Seroquel, Eliquis (blood thinner), and folic acid (vitamin).</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/20/24 at 10:10 AM, Administrative Nurse D verified the resident received Seroquel, an antipsychotic medication, with a diagnosis of Alzheimer's which was an inappropriate indication for the medication.</p> <p>The facility's Antipsychotic Medication Use policy, dated December 2016, recorded antipsychotic medication may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for appropriateness and indications for use.</p> <p>The facility failed to ensure R4 did not receive antipsychotic medication without an appropriate indication or the required physician documentation for its use placing R4 at risk for adverse medication side effects.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32360</p> <p>The facility had a census of 85 residents. The sample included 18 residents with eight reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to prevent significant medication errors for Resident (R) 15. This deficient practice placed the resident at risk for adverse medication reactions and physical decline.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R15's Electronic Medical Record (EMR) recorded diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough sepsis made or the body cannot respond to the insulin), hypotension (low blood pressure), and heart failure (a condition with low heart output and the body becomes congested with fluid). <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented R15 had moderately impaired cognition and required substantial/maximum assistance for toileting, showering, and personal hygiene. R15 required supervision for transfers. R15 did not ambulate. R15 was on dialysis (a procedure where impurities or wastes were removed from the blood). R15 received anticoagulant (decreases the blood's ability to clot) medication daily.</p> <p>R15's Medicare 5-Day MDS, dated [DATE], documented R15 had moderately impaired cognition and required supervision for ambulation and toileting. R15 was independent for mobility, and transfers, and was on dialysis. R15 received an anticoagulant and diuretic (medication to promote the formation and excretion of urine) medication daily.</p> <p>R15's Care Plan, dated 12/13/23, initiated on 09/25/23, directed staff to encourage adequate fluid intake and a healthy diet. Staff were to give medications as ordered, monitor for side effects, and obtain diagnostic work as ordered.</p> <p>The Physician's Order, dated 11/13/23, directed staff to administer midodrine (treats low blood pressure), 10 milligrams (mg), by mouth, three times a day and hold if his systolic blood pressure (SBP-the top number that measures the force the heart exerts on the walls of the arteries each time it beat) was greater than (>) 110 millimeters of mercury (mmHg). The medication was discontinued on 03/20/24.</p> <p>R15's Medication Administration Record (MAR), dated January 2024, documented 29 times out of 93 opportunities R15 received the midodrine medication when his blood pressure was above the ordered parameters.</p> <p>R15's MAR dated February 2024 documented 39 times out of 87 opportunities R15 received the midodrine medication when his blood pressure was above the ordered parameters.</p> <p>R15's MAR dated March 2024, documented six times out of 60 opportunities R15 received the midodrine medication when his blood pressure was above the ordered parameters.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Physician's Order, dated 01/27/24, directed staff to administer metoprolol (treats high blood pressure) 25 mg twice per day; hold if the SBP was less than (<) 110 mmHg.</p> <p>R15's MAR dated February 2024 documented one time out of 62 opportunities R15 received the metoprolol medication when his blood pressure was below the ordered parameters.</p> <p>R15's MAR dated March 2024, documented two times out of 40 opportunities R15 received the metoprolol medication when his blood pressure was below the ordered parameters.</p> <p>On 03/14/24 at 07:32 AM, observation revealed R15 watched television in his room.</p> <p>On 03/14/24 at 11:15 AM, Administrative Nurse D stated the medications should have been held when the blood pressures were outside of the ordered parameters. Administrative Nurse D said the pharmacist sent a recommendation in February documenting the errors of the medications and a nurse provided education to the staff that made the errors.</p> <p>On 03/18/24, at 09:26 AM, Certified Medication Aide (CMA) R stated she received education regarding the medication errors and when the medications should be held but she said she still did not understand what the < or > symbols meant so she did not know for sure when to hold the medication.</p> <p>On 03/20/24 at 09:30 AM, Licensed Nurse (LN) G stated in a perfect world the CMA would tell him when the blood pressure was out of parameters but that did not always happen. LN G said when R15 went to dialysis, he looked at the vitals section in the EMR but not specifically in the MAR, so he would not know if R15's blood pressure was out of parameters for the medication.</p> <p>On 03/20/24 at 09:30 AM, Administrative Nurse D stated she re-educated the staff members about the medication errors but had not performed a medication administration competency on any of the staff who had made the errors. Administrative Nurse D stated staff members should have reached out to her if they did not understand the order.</p> <p>The facility's Adverse Consequences and Medication Errors policy, dated 04/14, documented the facility staff monitored residents taking certain combinations of medications for possible adverse consequences and/or the need to modify the dose of one or more medications. The prescriber documented why or how these medications' benefits outweigh the risks in the resident's clinical record. In the event of a significant medication-related error or adverse consequence, immediate action was taken, as necessary, to protect the resident's safety and welfare. The QAPI (Quality Assurance and Performance Improvement) committee would conduct root cause analysis of medication administration errors to determine the source of errors, implement process improvement steps, and compare results over time to determine that system improvements are effective in reducing errors.</p> <p>The facility failed to keep R15 free from significant medication errors when staff failed to hold the medication when R15's blood pressures were out of physician-ordered parameters. This placed R15 at risk of adverse effects related to medication errors.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>27168</p> <p>The facility had a census of 85 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to date Resident(R)34 and R13's insulin (a hormone that allows cells throughout the body to uptake glucose) flex pen when opened and failed to discard R38's insulin flex pen when outdated. This deficient practice placed the affected residents at risk for ineffective medications.</p> <p>Findings included:</p> <p>- On 03/13/24 at 08:25 AM, observation of the facility's 300 and 400 medication carts revealed the following:</p> <p>R34's Humalog (fast-acting insulin) flex pen lacked an open date and discard date.</p> <p>R13's Humalog lacked an open and discard date.</p> <p>R38's Lantus (long-acting insulin) vial had an opened date of 02/06/24 (discard date of 03/05/24).</p> <p>On 03/20/24 at 09:00 AM, Administrative Nurse D verified the nurses were to date the insulin when opened and discard the outdated insulin. Administrative Nurse D said the night nurse should check the carts for expired medications and every nurse that administered medications should review the insulin to be sure the medication was not outdated.</p> <p>Medlineplus.gov directs open, unrefrigerated Humalog pens can be used within 28 days; after that time, they must be discarded; Unrefrigerated vials or pens of Lantus can be used within 28 days but after that time they must be discarded.</p> <p>The facility's Insulin Administration policy dated September 2014, documented the type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to ensure that it corresponds with the order on the medication sheet and the physician's order. The nurse would check the expiration date if drawing from an opened multi-dose vial. If opening a new vial, record the expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).</p> <p>The facility failed to date R34 and R13's insulin with the date opened and discard date and failed to discard R38's outdated insulin vial. This placed the residents at risk for ineffective medications.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37450</p> <p>The facility had a census of 85 residents. Based on observation, record review, and interview, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as air-conditioning units in large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by legionella). The facility further failed to ensure adequate infection control practices related to catheter (a tube inserted into the bladder to drain urine) care. These deficient practices placed the residents at increased risk for transmission of infectious diseases.</p> <p>Findings included:</p> <p>- On 03/20/24 at 02:39 PM, Maintenance Staff U and Administrative Staff A reported they were not aware of a required water management program to prevent waterborne pathogens (organisms causing disease) and verified the facility had no current program.</p> <p>The facility's Water Management Plan policy, dated 04/01/22, documented the intent and content of this policy as one component of compliance for Skilled Nursing Facilities that the facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help to prevent the development of and transmission of communicable diseases. The Centers for Medicare and Medicaid Services (CMS) requires Nursing Home Operators to develop a Water Management Program to Reduce Legionella Growth and Spread in Buildings.</p> <p>The facility failed to implement a water management program to manage waterborne pathogens placing the residents who resided in the facility at risk of contracting Legionella pneumonia.</p> <p>26768</p> <p>- On 03/14/24 at 02:45 PM, observation revealed Resident(R)17 in bed with a urinary catheter drainage bag hung on the side of her bed with no privacy bag; urine was visible from the hall. Observation revealed Certified Medication Aide (CMA) S placed a measuring container on R17's bare floor, provided urinary catheter care, and then emptied the Foley bag of 800 milliliters (ml) of yellow urine. She did not disinfect the port. CMA S emptied and rinsed the measuring container and did not change gloves or wash her hands before she handled and emptied the nephrostomy (an artificial opening created between the kidney and the skin which allows for the urinary diversion) bag of 50 ml yellow urine. CMA S did not disinfect the nephrostomy port.</p> <p>On 03/18/24 at 11:28 AM, observation revealed Certified Nurse Aide (CNA) M donned gloves, set a measuring container (dated 3/10) on R17's bare floor, and emptied urine from the Foley bag. Without changing gloves or washing her hands, CNA M emptied the nephrostomy bag. CNA M rinsed the measuring container with water and wiped the inside and out with a paper towel. She did not place the catheter bag into a privacy bag before leaving the room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 03/18/24 at 01:22 PM, observation revealed CNA N emptied R29's urinary catheter. She set a measuring container on the bare, visibly soiled floor. She then wiped the catheter bag port with a moist wipe (no disinfectant) and began to drain the urine. During draining, the port end touched inside of the used canister, which was dated 03/16/24. After draining the bag, she used a moist wipe (with no disinfectant) on the port, rinsed the measuring container with water, then wiped the inside and outside of it. CNA N did not place the drainage bag in a privacy bag.</p> <p>On 03/13/24 at 07:46 AM, R29 stated the urinary catheter bag was on the floor frequently.</p> <p>On 03/13/24 at 10:23 AM, Certified Medication Aide (CMA) T verified the catheter bag should not be allowed on the floor and stated R29 finished antibiotic treatments for a urinary tract infection recently.</p> <p>On 03/18/24 at 01:30 PM, Licensed Nurse (LN) G stated staff should not allow the urinary catheter bag to lie on the floor and said staff should put the catheter bag in a privacy bag. He stated staff should place a clean barrier on the floor when draining the urine collection bag. LN G said staff should use a cleaning wipe or alcohol pad on the port and confirmed staff were to change the measuring canisters weekly and as needed.</p> <p>On 03/18/24 at 12:20 PM, Administrative Nurse E stated staff should place the Foley bag in a privacy bag. Administrative Nurse E said staff should not place the canister on the bare floor, and staff should change gloves and wash hands between emptying the Foley and the nephrostomy bags. She stated staff should use an alcohol wipe on the port.</p> <p>On 03/18/24 at 01:35 PM, Administrative Nurse D verified staff should not allow the urinary catheter bag to lie on the floor and said staff should put the catheter bag in a privacy bag. Administrative Nurse D said staff should place a clean barrier on the floor when draining the catheter bag and use an alcohol wipe on the port.</p> <p>On 03/20/24 at 09:27 AM, Administrative Nurse D verified staff should not place the canister on the bare floor. Administrative Nurse D said staff should change gloves and wash hands between the Foley and the nephrostomy bags and should use an alcohol wipe on the port.</p> <p>The facility's Catheter Care, Urinary policy, dated 2014, directed staff to maintain an accurate record of the daily output, keep the tubing free of kinks, and always position the drainage bag lower than the bladder. Staff were to maintain a clean technique when handling or manipulating the catheter, tubing, or drainage bag. Staff were to ensure the catheter tubing and drainage bag were kept off the floor, empty the drainage bag at least every eight hours, and prevent contact of the drainage spigot with the nonsterile collection container.</p> <p>The facility failed to provide appropriate infection control practices when handling R17's urinary catheter and nephrostomy bag and R29's urinary catheter bag. This placed R17 and R29 at increased risk for infection.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175215	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Tonganoxie Terrace		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 East Street Tonganoxie, KS 66086	
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)		
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>37450</p> <p>The facility had a census of 85 residents, with 18 residents included in the sample. Five nurse aide staff were reviewed for the required training. Based on observation, record review, and interview, the facility failed to provide the required 12 hours of in-service education for Certified Medication Aide (CMA) R, CMA RR, and CMA SS. This deficient practice placed the residents at risk of receiving impaired care.</p> <p>Findings included:</p> <p>- A review of the facility's 12-hour annual in-service documentation revealed CMA R, CMA RR, CMA SS, and CNA P lacked documentation of the required 12 hours of in-service education.</p> <p>On 03/20/24 at 10:34 AM, Administrative Nurse D stated she served the role of Director of Nursing since 11/2023. Administrative Nurse D stated she should have a skills fair for in-service and competency assessment related to nursing care. Administrative Nurse D verified the lack of evidence the sampled CNA staff had the required 12 hours of in-service.</p> <p>The facility's Competency of Nursing Staff policy, undated, documented all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. In addition, licensed nurses and nursing assistants employed by the facility will participate in facility-specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. Facility and resident-specific competency evaluations will be conducted upon hire, annually, and as deemed necessary. Competency demonstration will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge.</p> <p>The facility failed to provide the required 12 hours of in-service for CNA staff. This deficient practice placed residents at risk of receiving impaired care.</p>		