STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Fort Scott	915 S Horton Fort Scott, KS 66701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 45668 The facility identified a census of 37 residents. The sample included 12 residents. Based on record review, observation, and interviews, the facility failed to post the State Survey Agency (SSA) contact information on how to report abuse in a manner accessible to the residents and their representatives. This deficient practice placed the residents at risk for ongoing abuse and other concerns. Findings Included: - On 04/01/24 at 07:20 AM a walkthrough of the facility was completed. Upon inspection of the facility's television area, a small 8-inch by 10-inch (8x10) poster with small black writing was posted by the main entry door to the room four feet high on the wall. The poster displayed the SSA contact information and instructions related to reporting complaints related to abuse. A walkthrough of the center hall revealed an 8x10 poster with a small black font on the wall placed behind two Hoyer lifts (total body mechanical lift). The poster was placed six feet away from the view of the hall. On 04/02/24 at 10:15 AM, the Resident Council members reported they were not aware of the location of the SSA contact information. On 04/03/23 at 12:45 PM Resident (R)16, a cognitively intact resident, sat in her wheelchair next to the piano in the lobby. Upon request, R16 attempted to read the state agency contact poster. R16 reported she could not read the poster from two feet away from it. R16 reported she could not read the state contact poster in the hallway behind the Hoyer lifts. On 04/03/24 at 02:30 PM, Licensed Nurse (LN) G reported the required contact posters should place in a highly visible area and big enough for everyone including the residents to read. She stated many of the residents have difficulty seeing small letters and require larger signs to read. On 04/03/24 at 03:30 PM Administrative Nurse D stated the required contact information should be posted in a manner visible and understandable to the residents. The facility's provided Your Rights and Protections as a Nursing Home Resident policy (undated) indicated the facility must provide the contact information to report mistreatment or concerns to the Long-Term Care Ombudsman, and State Survey Agency. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Medicalodges Fort Scott		STREET ADDRESS, CITY, STATE, ZIP CODE 915 S Horton Fort Scott, KS 66701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to post the SSA information in a manner accessible to the residents and their representatives. This deficient practice placed the residents at risk for ongoing abuse and unresolved grievances and concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175258	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 49634 The facility identified a census of 37 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to ensure the residents received their mail services on Saturdays. Findings Included: - On 04/02/24 at 10:15 AM, Resident Council members reported that the facility does not provide mail services for the residents on Saturdays. The council reported they receive mail Monday through Friday, but there is no one to pick up and pass mail on Saturdays. On 04/03/2 at 10:31 AM Activities Coordinator (AC) Z reported that she would get the mail if Administrative Staff A was not going to be at the facility on Monday through Friday. AC Z stated there was no one at the facility to pick up the resident's mail on Saturdays. On 04/03/24 at 10:40 AM Administrative Nurse D stated that she picked up mail Monday through Friday, but she was not at the facility on Saturdays. She stated she was trying to get a box at the facility to ensure residents would be able to get their mail on Saturdays. The facility did not provide a policy related to mail delivery. The facility failed to ensure the residents received their mail services on Saturdays.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 45668 The facility identified a census of 37 residents. The sample included 12 residents. Based on interviews and observations, the facility failed to post the previous state inspection information in a location accessible to the residents and visitors. Findings Include: - On 04/01/24 at 07:10 AM an initial walkthrough of the facility revealed a sign posted Survey Results in the main lobby with an arrow pointing down to the ground. An inspection of the ground and surrounding area revealed no previous survey results. On 04/02/24 at 10:15 AM the resident council reported they were unaware of where the survey book was located. The council reported a sign in the main lobby behind a recliner but not sure where the book was located. On 04/03/24 at 11:00 AM an inspection of the facility revealed no posted survey results accessible to the residents or their representatives. On 04/03/24 at 11:30 AM Administrator A stated the survey binder had been in Administrative Nurse D's office, but she was not sure why. She stated the book was moved back to the table in the main lobby. The facility did not provide a policy. The facility failed to post the state inspection survey results in a place available to the residents and representatives.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 49634 The facility identified a census of 37 residents with 12 residents included in the sample. The facility identified six residents who were discharged from Medicare Part A services. Based on interview and record review the facility failed to issue CMS (Center for Medicare/Medicaid Services) Notification of Medicare Non-Coverage Form 10123 (NOMNC- the form used to notify Medicare A participants of their rights to appeal and the last covered date of participants of potential financial liability when a Medicare Part A episode ends) with the required information for Resident (R) 88 and R 89. This failure placed the residents at risk for decreased autonomy and impaired decision-making. Findings included: - A review of R88's Electronic Medical Record (EMR) documented that the Medicare Part A episode began on 12/09/23 and ended on 12/21/23. R88 did not remain in the facility for custodial care. The facility was unable to provide documentation a NOMNC was issued for R88. A review of R89's EMR documented that the Medicare Part A episode began on 9/27/23 and ended on 11/03/24. R89 did not remain in the facility for custodial care. The facility was unable to provide documentation a NOMNC was issued for R89. On 04/03/24 at 10:45 AM Administrative Staff A stated she was unsure where the forms were. She stated she was unable to find any documentation that R88 and R89 had received a NOMNC. The facility did not provide a policy for beneficiary notification. The facility failed to ensure a NOMNC was provided at the end of skilled services for R88 and R89. This failure placed the residents at risk for decreased autonomy and impaired decision-making.

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	175258	A. Building B. Wing	04/03/2024

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 45668 The facility identified a census of 37 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances and concerns. Findings Included: - On 04/02/24 at 08:00 AM an inspection of the facility revealed no designated grievance drop boxes or system available in the areas accessible to the residents and visitors of the facility. On 04/02/24 at 10:15 AM, the Resident Council members reported they were not aware if the facility provided a way to complete anonymous grievances. The council reported Administrative Staff A was responsible for complaints and grievances. The council reported they did not know of a grievance box or forms. On 04/03/24 at 11:45 AM Social Services X reported she was not aware of any way for the residents or their visitors to file grievances anonymously. On 04/03/24 at 03:50 PM Administrator A stated she handled the facility's grievances. She stated she currently did not have a posted grievance dropbox, but the residents could call the corporate complaint line to file a grievance. She stated staff could receive the grievances and file them for the residents as well. The facility's provided Grievance policy revised (undated) indicated the facility would ensure each resident's right to file a grievance in writing, verbally, or anonymously. The policy indicated the facility would ensure the grievances were documented and ensure all written decisions included corrective actions and prompt resolution. The policy noted the grievance documentation will be kept for three years beyond the written decision. The facility failed to implement a system to allow residents and/or their representatives to file grievances anonymously within the facility. This deficient practice placed the residents at risk for decreased psychosocial well-being and unresolved grievances.

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F 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41037

The facility identified a census of 37 residents. The sample included 12 residents with two residents reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide written notice of transfer or discharge notice for Resident (R) 10's facility-initiated transfers. This deficient practice placed R10 at risk of uninformed choices and miscommunication regarding care needs.

Findings included:

- R10's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), and a contracture (abnormal permanent fixation of a joint or muscle).

The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented no upper or lower extremity impairment for R10 during the observation period.

The Quarterly MDS dated [DATE] documented a BIMS score of 10 which indicated moderately impaired cognition. The MDS documented that R10 had upper and lower extremity impairment on one side during the observation period.

R10's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/26/23 documented he had impaired mobility and required extensive assistance from three staff members for transfers. R10's plan of care would direct staff to assist him in maintaining his level of care and prevent a decline in his ability to participate in his care.

R10's Care Plan dated 05/20/21 documented that staff would assist him in setting a realistic goal to make his life as comfortable as possible.

R10's EMR under the Progress Notes tab revealed a nurse's note on 09/28/223 at 04:40 PM that documented R10 was transported to the hospital.

On 11/09/23 at 10:43 AM a Nursing Progress Note documented R16 was transferred to the hospital.

On 12/14/23 at 03:25 AM a Nursing Progress Note documented R10 was admitted to the hospital.

On 02/21/24 at 04:05 AM a Nursing Progress Note documented R10 was admitted to the hospital on 02/20/24.

On 03/20/24 at 07:15 AM a Nursing Progress Note documented R10 was admitted to the hospital.

(continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide evidence a written notice of transfer or discharge notification was provided to the legal representative when R10 transferred to the hospital on the above dates upon request. On 04/02/24 at 09:55 AM R10 sat slightly reclined in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the common area. R10's contracted left hand lay on his abdomen. R10's left hand did not have a washcloth or carrot in his palm. On 04/02/24 at 04:05 PM Administrative Staff A stated the facility had not provided a written notice of transfer or discharge notice to R10 or his legal representative for R10's hospitalization s. The facility did not provide a policy related to transfers and discharges, The facility failed to provide a written notice of transfer or discharge notice for R10's facility-initiated transfers. This deficient practice placed R10 at risk of uninformed choices and miscommunication regarding care needs.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 37 residents. The sample included 12 residents with two residents reviewed for hospitalization . Based on observation, record review, and interviews, the facility failed to provide a bed hold notice when Resident (R) 10 was hospitalized . This deficient practice placed R10 at risk of uninformed choices. Findings included: - R10's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), and a contracture (abnormal permanent fixation of a joint or muscle). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented no upper or lower extremity impairment for R10 during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 10 which indicated moderately impaired cognition. The MDS documented that R10 had upper and lower extremity impairment on one side during the observation period. R10's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/26/23 documented he had impaired mobility and required extensive assistance from three staff members for transfers. R10's plan of care would direct staff to assist him in maintaining his level of care and prevent a decline in his ability to participate in his care. R10's Care Plan dated 05/20/21 documented that staff would assist him in setting a realistic goal to make his life as comfortable as possible. R10's EMR under the Progress Notes tab revealed a nurse's note on 09/28/223 at 04:40 PM that documented R10 was transported to the hospital. On 11/09/23 at 10:43 AM a Nursing Progress Note documented R16 was transferred to the hospital. On 12/14/23 at 03:25 AM a Nursing Progress Note documented R10 was admitted to the hospital. On 02/21/24 at 04:05 AM a Nursing Progress Note documented R10 was admitted to the hospital on 02/20/24. On 03/20/24 at 07:15 AM a Nursing Progress Note documented R10 was admitted to the hospital. The facility was unable to provide evidence a bed hold notification was provided to the legal representative when R10 transferred to the hospital on the above dates upon request. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/24 at 09:55 AM R10 sat slightly reclined in his Broda chair (specialized wheelchair with the ability to tilt and recline) in the common area. R10's contracted left hand lay on his abdomen. R10's left hand did not have a washcloth or carrot in his palm. On 04/02/24 at 04:05 PM Administrative Staff A stated the facility had not provided a bed hold notice to R10 or his legal representative for R10's hospitalization s. The facility did not provide a policy related to transfers and discharges. The facility failed to provide a bed hold notice for R10 hospitalization . This deficient practice placed R10 at risk of uninformed choices.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 37 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to review and revise the care plan with resident-specific interventions for Resident (R)7, R10, R25, and R14. This deficient practice placed the residents at risk for impaired care due to uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R7's Electronic Medical Records (EMR) included diagnoses of morbid obesity (severely overweight), chronic obstructive pulmonary disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, and respiratory failure. R7's Quarterly Minimum Data Assessment (MDS) completed 02/02/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated he required substantial to maximal assistance with bed mobility, transfers, personal hygiene, dressing, and bathing. The MDS indicated he had no pressure ulcers but was at risk for developing them. The MDS noted he was on a turning/repositioning program and received ointment and medications. The MDS noted he had pressure-relieving devices for his chair and bed. R7's Pressure Ulcer Care Area Assessment (CAA) completed 08/12/23 indicated he was at risk for pressure ulcer development due to his decreased mobility. The CAA noted he had a pressure-reducing cushion in his wheelchair and a pressure-relieving mattress on his bed. The CAA noted he used an overhead trapeze to assist with repositioning. The CAA indicated a care plan would be developed to minimize the risk of occurrences. R7's Care Plan initiated 09/01/17 indicated he was at risk for skin breakdown and pressure ulcers. The plan indicated he required assistance from staff to complete his activities of daily living (ADLs) due to his physical limitations. The plan indicated he should be repositioned every two hours to prevent skin breakdown. The plan noted he had no actual pressure-related injuries but was at risk. The plan lacked documentation related to his low air-loss mattress on his bed or the correct settings. A Skin/Wound Condition assessment completed on 03/15/24 noted no wound or skin conditions. The assessment indicated he had a low air-loss or alternating pressure air mattress as a preventative measure for pressure injuries. R7's EMR indicated he weighed 338 pounds (lbs.) on 03/27/24. R7's EMR lacked instructions related to his low air-loss mattress or pump settings. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the low air-loss mattress manufacturer's operation (Drive Model #14048) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range selected. The manual recommended the pump be set based on the resident's weight. The manual indicated the firmness of the mattress could be set within 50 lbs. weight intervals. On 04/01/24 at 07:05 AM R7 slept in his bed. His bed contained a low air-loss mattress and a Drive Model 14048 pump. The pump's weight range was [PHONE NUMBER] lbs. capacity with weight ranges set at 50 lb. increments. R7's pump was set up for 400-450 lbs. range. On 04/02/24 at 09:21 AM R7 sat in his recliner. He stated he had skin breakdown when he first arrived at the facility and the bed was brought in. He stated the bed could be uncomfortable and he was not sure if staff checked the settings on it. Observation revealed R7's pump was set at the 400-450lbs range. R7 stated he has never weighed 400lbs. On 04/02/24 at 11:45 AM Certified Nurses Aid (CNA) stated the pump instructions should be listed in the care plan to inform staff how it should be set. On 04/02/24 at 02:40 PM, Licensed Nurse (LN) G stated she was not sure if the care plan or orders contained instructions for his mattress pump. On 04/03/24 at 03:30 PM Administrative Nurse D stated all staff had access to the care plans. Administrative Nurse D stated she expected the care plan to be updated within one to two days after learning of new issues or interventions. Administrative Nurse D stated she expected all staff to review and follow the residents' plans. Administrative Nurse D acknowledged the care plans had not been updated as they should have before January and said it was a work in progress. The facility did not provide a policy related to care plan creation or revision. The facility failed to review and revise the care plan with resident-specific interventions for R7. This deficient practice placed the residents at risk for impaired care due to uncommunicated care needs. 41037 - R10's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), and a contracture (abnormal permanent fixation of a joint or muscle). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented no upper or lower extremity impairment for R10 during the observation period. The MDS documented R10 was dependent on staff for most activities of daily living (ADL) but was able to feed himself after set-up assistance from staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS dated [DATE] documented a BIMS score of 10 which indicated moderately impaired cognition. The MDS documented that R10 had upper and lower extremity impairment on one side during the observation period. The MDS documented R10 was dependent on staff for most ADL but was able to feed himself after set-up assistance from staff. R10's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/26/23 documented he had impaired mobility and required extensive assistance from three staff members for transfers. R10's plan of care would direct staff to assist him in maintaining his level of care and prevent a decline in his ability to participate in his care. R10's Care Plan dated 05/18/22 directed staff to place a washcloth in R10's hand to protect his palm from his fingernails. The plan of care lacked direction for a left-hand splint. R10's EMR under the Documentation Survey Reports under Tasks documented: Restorative: Splint/brace- apply elbow brace, hand splint, and carrot daily to the left hand. The resident was to wear the splint throughout the day for contracture. R10's EMR under Tasks reviewed from 01/01/24 through 03/31/24 lacked documentation that the splint was applied to R10's left hand. On 04/01/24 at 09:53 AM R10 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room. R10's left contracted left hand laid on his chest with his fingers tightly gripped. R10's left hand did not have a washcloth or carrot in his palm or a splint/brace on his left elbow. R10 stated the staff had not placed a washcloth in his left palm for a long time and said he probably should have one in his hand. On 04/02/24 at 09:55 AM R10 sat slightly reclined in his Broda chair in the common area. R10's contracted left hand lay on his abdomen. R10's left hand did not have a washcloth or carrot in his palm and no splint/brace on his left elbow. On 04/03/24 at 02:30 PM, Certified Nurse Aide (CNA) O stated the dayshift would apply any splints or braces. CNA O stated she had not seen a splint for R10. CNA O stated she had not been told R10 should have a washcloth in his left hand. On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated restorative service was provided depending on staffing levels. LN G stated she was not aware R10 was to wear a splint or brace. On 04/03/24 at 03:30 PM Administrative Nurse D stated all staff had access to the care plans. Administrative Nurse D stated she expected the care plan to be updated within one to two days after learning of new issues or interventions. Administrative Nurse D stated she expected all staff to review and follow the residents' plans. Administrative Nurse D acknowledged the care plans had not been updated as they should have before January and said it was a work in progress. The facility did not provide a policy related to care plan creation or revision. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Medicalodges Fort Scott		STREET ADDRESS, CITY, STATE, ZIP CODE 915 S Horton Fort Scott, KS 66701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to review and revise the care plan with resident-specific interventions for R10. This deficient practice placed the resident at risk for impaired care due to uncommunicated care needs. - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit. The Significant Change Minimum Data Set (MDS) dated [DATE] documented severely impaired cognition. The MDS documented R25 was dependent on staff assistance for all activities of daily living. The MDS documented R25 had difficulty with his hearing and did not wear hearing aids during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of eight which indicated moderately impaired cognition. The MDS documented that R25 required substantial to maximum assistance with personal hygiene. The MDS documented R10's hearing was adequate with the assistance of his hearing aids. R25's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/24/23 documented R25 had severe cognitive impairment. R25's Care Plan dated 03/15/23 documented R25 had hearing aids that needed to be charged nightly. The plan of care lacked direction to the staff related to the application of R25's hearing aids. On 04/01/24 at 12:36 PM staff pushed R25 into the dining room table in his wheelchair and left the dining room. Another resident attempted to talk with R25. R25 stated he could not hear this resident because his hearing aids had been lost again. Certified Nurse Aide (CNA) Q entered the dining room and placed hearing aids into R25's ears. On 04/02/24 at 08:07 AM R25 sat in his wheelchair at the dining room table without his hearing aids. One of his table mates attempted to talk to R25. R25 was unable to hear what was said to him. R25 stated he could not hear; his hearing aids had been lost. On 04/03/24 at 09:57 AM, Administrative Nurse D stated R25 had lost a pair of hearing aids, but he currently had hearing aids to use. Administrative Nurse D stated she was not aware of any specific staff assigned to ensure R25's hearing aids were placed in his ears to assist him with being able to participate with his ADLs. Administrative Nurse D stated that R25 could understand if he was facing the person who was speaking. Administrative Nurse D stated R25 would stop by the nurse's desk if someone was there to ask for his hearing aids. Administrative Nurse D stated she was not aware that R25 believed his hearing aids had been lost. On 04/03/24 at 03:30 PM Administrative Nurse D stated all staff had access to the care plans. Administrative Nurse D stated she expected the care plan to be updated within one to two days after learning of new issues or interventions. Administrative Nurse D stated she expected all staff to review and follow the residents' plans. Administrative Nurse D acknowledged the care plans had not been updated as they should have before January and said it was a work in progress. The facility did not provide a policy related to care plan creation or revision. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Medicalodges Fort Scott		STREET ADDRESS, CITY, STATE, ZIP CODE: 915 S Horton Fort Scott, KS 66701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to review and revise the care plan with resident-specific interventions for R25. This deficient practice placed the residents at risk for impaired care due to uncommunicated care needs. 49634 - R14's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or never problems), dysphagia (swallowing difficulty), and aphasia (condition with disordered or absent language function). The Significant Change Minimum Data Set (MDS) dated [DATE] did not document a Brief Interview of Mental Status (BIMS). The MDS documented that R14 required partial/moderate assistance with toileting, showers, and eating. The MDS documented R14 received a diuretic (medication to promote the formation and excretion of urine) during the observation period. R14's Communication Care Area Assessment (CAA) dated 02/09/24 documented R14 was alert to person and was nonverbal. He could indicate by nodding his head to yes or no questions. He also had a picture book where he could point to objects, which he seldom used. R14's Care Plan revised 08/25/22 documented R14 received a diuretic with a Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration). The plan lacked direction related to weight monitoring for CHF. R14's EMR under the Orders tab dated 04/27/21 revealed the following physician orders: Lasix (diuretic) tablet 20 milligrams; give one tablet by mouth one time a day related to CHF. Daily weights every day dated 02/17/24, for the diagnosis of CHF. Review of R14's Medication Administration Record (MAR) from 02/17/24 to 04/03/24 (45 days) lacked evidence staff measured and recorded R14's weight on the following dates 02/17, 02/18, 02/21, 02/22, 2/26, 2/27, 03/01, 03/02, 03/03, 03/06, 03/07, 03/11, 03/12, 03/15, 03/16, 03/17, 03/20, 03/25, 03/26, 03/28, 03/29, 03/30, 03/31 and 04/02. R14's clinical record lacked documentation of physician notification the daily weight was not obtained and lacked evidence R14 refused to be weighed. On 04/02/24 at 09:19 AM R14 sat in his wheelchair playing hit the balloon with peers during an activity. On 04/03/24 at 02:20 PM, Certified Nursing Aide (CNA) O stated nursing would let the CNA staff know if ta residents needed to be weighed. CNA O stated the nurses usually made a list of residents who needed to be weighed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/24 at 02:43 PM Licensed Nurse (LN) G stated that occasionally she did not have time to obtain weights. LN G stated if she did not have time to get the weight, she also did not have time to notify the physician of the missed weight. On 04/03/24 at 03:30 PM Administrative Nurse D stated all staff had access to the care plans. Administrative Nurse D stated she expected the care plan to be updated within one to two days after learning of new issues or interventions. Administrative Nurse D stated she expected all staff to review and follow the residents' plans. Administrative Nurse D acknowledged the care plans had not been updated as they should have before January and said it was a work in progress. The facility did not provide a policy related to care plan creation or revision. The facility failed to review and revise the care plan with resident-specific interventions for R14. This deficient practice placed the residents at risk for impaired care due to uncommunicated care needs.

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Medicalodges Fort Scott	915 S Horton Fort Scott, KS 66701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0676

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41037

The facility identified a census of 37 residents. The sample included 12 residents with three residents reviewed for activities of daily living (ADL). Based on record review, and interviews, the facility failed to ensure Resident (R) 25 received the necessary ADL assistance he required for his hearing aids. This deficient practice placed R25 at risk for the inability to communicate with peers or staff, increased confusion, negative psychosocial outcomes, and decreased dignity.

Findings included:

- R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit.

The Significant Change Minimum Data Set (MDS) dated [DATE] documented severely impaired cognition. The MDS documented R25 was dependent on staff assistance for all activities of daily living. The MDS documented R10 had difficulty with his hearing and did not wear hearing aids during the observation period.

The Quarterly MDS dated [DATE] documented a BIMS score of eight which indicated moderately impaired cognition. The MDS documented that R25 required substantial to maximum assistance with personal hygiene. The MDS documented R25's hearing was adequate with the assistance of his hearing aids.

R25's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/24/23 documented R25 had severe cognitive impairment.

R25's Care Plan dated 03/15/23 documented R25 had hearing aids that needed to be charged nightly. The plan of care lacked direction to the staff related to the application of R25's hearing aids.

On 04/01/24 at 12:36 PM staff pushed R25 into the dining room table in his wheelchair and left the dining room. Another resident attempted to talk with R25. R25 stated he could not hear this resident because his hearing aids had been lost again. Certified Nurse Aide (CNA) Q entered the dining room and placed hearing aids into R25's ears.

On 04/02/24 at 08:07 AM R25 sat in his wheelchair at the dining room table without his hearing aids. One of his table mates attempted to talk to R25. R25 was unable to hear what was said to him. R25 stated he could not hear; his hearing aids had been lost.

On 04/03/24 at 09:48 AM Consultant HH stated she understood R25's hearing had been discarded into the trash. Consultant HH stated R25 had placed his hearing aids into a Kleenex, and then attempted to give his hearing aids to the staff member. Consultant HH stated the facility staff member instructed R25 to throw the Kleenex in the trash. Consultant HH stated the facility had located an old pair of R25's hearing aids and was using those.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 09:57 AM, Administrative Nurse D stated R25 had lost a pair of hearing aids, but he currently had hearing aids to use. Administrative Nurse D stated she was not aware of any specific staff assigned to ensure R25's hearing aids were placed in his ears to assist him with being able to participate with his ADLs. Administrative Nurse D stated R25 could understand if he was facing the person who was speaking. Administrative Nurse D stated R25 would stop by the nurse's desk if someone was there to ask for his hearing aids. Administrative Nurse D stated she was not aware that R25 believed his hearing aids had been lost. The facility was unable to provide a policy related to maintaining a resident's hearing. The facility failed to ensure assistance was provided for R25's hearing aids to aid his ability to participate with ADLs. This deficient practice placed R25 at risk for the inability to communicate with peers or staff, increased confusion, negative psychosocial outcomes, and decreased dignity.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 49634 The facility identified a census of 37 residents. The sample includes 12 residents. Based on observation, record review, and interviews, the facility failed to provide consistent weekend activities. This deficient practice placed the affected residents at risk for decreased psychosocial well-being. Findings included: - A review of the facility's Activity Calendar for January, February, and March 2024 was completed. The review revealed no activities on Saturdays and Sundays. The calendar indicated church services were provided on Sunday afternoons. On 04/03/24 at 10:15 AM, Resident Council members reported activities rarely occurred on weekends compared to the weekdays. The council reported due to the low staffing in the facility there was no activity person on the weekend. The council reported they could read books, and there were extra coloring pages, or they could watch TV. The council reported they would like activities on the weekends, such as bingo or interactive groups on the weekend. On 04/03/24 at 12:55 PM, Certified Nurses Aid (CNA) Q stated staff used to have activities on the weekends, but now there was only church on Sundays. CNA Q stated most of the residents watched TV on the weekends, since that was all there was to do. On 04/03/24 at 10:51 AM Activities Staff Z reported the facility did not have activities on the weekends. Activities Staff Z stated there were things residents could do, like read books and there were always coloring pages left out for the residents. A review of the facility's Activities and Resident Rights policy revised 10/2019 indicated facility will promote and advocate the residents' rights in the provision of recreation services and to promote self-determination. The resident council is to be promoted and used as a way for soliciting new ideas and suggestion programs. The facility failed to provide consistent activities for the residents during weekends. This deficient practice placed the affected residents at risk for decreased psychosocial well-being.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample included 12 residents with one resident reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to follow a physician's order for daily weights to monitor for fluid overload for Resident (R) 14. This deficient practice placed R14 at risk for delay in treatment related to fluid overload and untreated illness. Findings included: - R14's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or never problems), dysphagia (swallowing difficulty), and aphasia (condition with disordered or absent language function). The Significant Change Minimum Data Set (MDS) dated [DATE] did not document a Brief Interview of Mental Status (BIMS). The MDS documented that R14 required partial/moderate assistance with toileting, showers, and eating. The MDS documented R14 received a diuretic (medication to promote the formation and excretion of urine) during the observation period. R14's Communication Care Area Assessment (CAA) dated 02/09/24 documented R14 was alert to person and was nonverbal. He could indicate by nodding his head to yes or no questions. He also had a picture book where he could point to objects, which he seldom used. R14's Care Plan revised 08/25/22 documented R14 received a diuretic with a Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration). The plan lacked direction related to weight monitoring for CHF. R14's EMR under the Orders tab dated 04/27/21 revealed the following physician orders: Lasix (diuretic) tablet 20 milligrams; give one tablet by mouth one time a day related to CHF. Daily weights every day dated 02/17/24, for the diagnosis of CHF. Review of R14's Medication Administration Record (MAR) from 02/17/24 to 04/03/24 (45 days) lacked evidence staff measured and recorded R14's weight on the following dates 02/17, 02/18, 02/21, 02/22, 2/26, 2/27, 03/01, 03/02, 03/03, 03/06, 03/07, 03/11, 03/12, 03/15, 03/16, 03/17, 03/20, 03/25, 03/26, 03/28, 03/29, 03/30, 03/31 and 04/02. R14's clinical record lacked documentation of physician notification the daily weight was not obtained and lacked evidence R14 refused to be weighed. On 04/02/24 at 09:19 AM R14 sat in his wheelchair playing hit the balloon with peers during an activity. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 02:20 PM, Certified Nursing Aide (CNA) O stated nursing would let the CNA staff know if ta residents needed to be weighed. CNA O stated the nurses usually made a list of residents who needed to be weighed. On 04/03/24 at 02:43 PM Licensed Nurse (LN) G stated that occasionally she did not have time to obtain weights. LN G stated if she did not have time to get the weight, she also did not have time to notify the physician of the missed weight. On 04/03/24 at 03:25 PM Administrative Nurse D stated she knew staff were behind on obtaining resident weights. She stated the facility was going to have the restorative aide do the weights. Administrative Nurse D stated if the restorative aid was not able to get the weights done, she would do it herself. The facility did not provide a policy for quality of care or following physician orders. The facility failed to follow a physician's order for daily weights to monitor for fluid overload for R14. This deficient practice placed R14 at risk for a delay in treatment related to fluid overload and untreated illness.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 37 residents. The sample included 12 with five reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R)7's pressure-reducing interventions were implemented correctly when his low air-loss mattress pump was inappropriately set for his current weight. This deficient practice placed the resident at risk for complications related to skin breakdown and pressure ulcers. Findings Included: - The Medical Diagnosis section within R7's Electronic Medical Records (EMR) included diagnoses of morbid obesity (severely overweight), chronic obstructive pulmonary disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, and respiratory failure. R7's Quarterly Minimum Data Assessment (MDS) completed 02/02/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated he required substantial to maximal assistance with bed mobility, transfers, personal hygiene, dressing, and bathing. The MDS indicated he had no pressure ulcers but was at risk for developing them. The MDS noted he was on a turning/repositioning program and received ointment and medications. The MDS noted he had pressure-relieving devices for his chair and bed. R7's Pressure Ulcer Care Area Assessment (CAA) completed 08/12/23 indicated he was at risk for pressure ulcer development due to his decreased mobility. The CAA noted he had a pressure-reducing cushion in his wheelchair and a pressure-relieving mattress on his bed. The CAA noted he used an overhead trapeze to assist with repositioning. The CAA indicated a care plan would be developed to minimize the risk of occurrences. R7's Care Plan initiated 09/01/17 indicated he was at risk for skin breakdown and pressure ulcers. The plan indicated he required assistance from staff to complete his activities of daily living (ADLs) due to his physical limitations. The plan indicated he should be repositioned every two hours to prevent skin breakdown. The plan noted he had no actual pressure related injuries but was at risk. The plan lacked documentation related to his low air-loss mattress on his bed or the correct settings. A Skin/Wound Condition assessment completed on 03/15/24 noted no wound or skin conditions. The assessment indicated he had a low air-loss or alternating pressure air mattress as a preventative measure for pressure injuries. R7's EMR indicated he weighed 338 pounds (lbs.) on 03/27/24. R7's EMR lacked instructions related to his low air-loss mattress or pump settings. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the low air-loss mattress manufacturer's operation (Drive Model #14048) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range selected. The manual recommended the pump be set based on the resident's weight. The manual indicated the firmness of the mattress could be set within 50 lbs. weight intervals. On 04/01/24 at 07:05 AM R7 slept in his bed. His bed contained a low air-loss mattress and a Drive Model 14048 pump. The pump's weight range was [PHONE NUMBER] lbs. capacity with weight ranges set at 50 lb. increments. R7's pump was set up for 400-450 lbs. range. On 04/02/24 at 09:21 AM R7 sat in his recliner. He stated he had skin breakdown when he first arrived at the facility and the bed was brought in. He stated the bed could be uncomfortable and he was not sure if staff checked the settings on it. Observation revealed R7's pump was set at the 400-450lbs range. R7 stated he has never weighed 400lbs. On 04/02/24 at 11:45 AM Certified Nurses Aid (CNA) stated the pump should be set based on R7's weight but usually was set up by maintenance. She stated she was not sure who checked the pump. She stated the pump instructions should be listed in the care plan to inform staff how it should be set. On 04/02/24 at 02:40 PM, Licensed Nurse (LN) G stated the low air-loss pumps were set to R7's weight. She stated he had no actual wounds but R7 was at risk due to his immobility and size. She stated she was not sure if the care plan or orders contained instructions for his mattress pump. On 04/02/24 at 03:30 PM, Administrative Nurse D stated staff were expected to check the settings of the mattresses daily. She stated the mattress pumps were set per the resident's weight and should be adjusted if incorrectly set. She stated she was not sure if in-service training had occurred related to low air-loss beds. A review of the facility's provided Wound Prevention and Management policy revised 12/2018 indicated the facility will provide pressure redistribution mattresses and pressure relieving devices as interventions to prevent pressure-related injuries. The policy indicated the facility will ensure the appropriate use and ongoing assessment of preventative interventions. The facility failed to ensure R7's low air-loss mattress pump was appropriately set to his current weight. This deficient practice placed both residents at risk for complications related to skin breakdown and pressure ulcers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41037

The facility identified a census of 37 residents. The sample included 12 residents with one resident reviewed for positioning and mobility. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 10 was provided services and treatment to prevent worsening of contractures (abnormal permanent fixation of a joint or muscle) in his left hand. This deficient practice placed R10 at risk for discomfort and decreased range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension).

Findings included:

- R10's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), and a contracture (abnormal permanent fixation of a joint or muscle).

The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight which indicated moderately impaired cognition. The MDS documented no upper or lower extremity impairment for R10 during the observation period. The MDS documented R10 was dependent on staff for most activities of daily living (ADL) but was able to feed himself after set-up assistance from staff.

The Quarterly MDS dated [DATE] documented a BIMS score of 10 which indicated moderately impaired cognition. The MDS documented that R10 had upper and lower extremity impairment on one side during the observation period. The MDS documented R10 was dependent on staff for most ADL but was able to feed himself after set-up assistance from staff.

R10's Activities of Daily Living Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 07/26/23 documented he had impaired mobility and required extensive assistance from three staff members for transfers. R10's plan of care would direct staff to assist him in maintaining his level of care and prevent a decline in his ability to participate in his care.

R10's Care Plan dated 05/18/22 directed staff to place a washcloth in R10's hand to protect his palm from his fingernails. The plan of care lacked direction for a left-hand splint.

R10's EMR under the Documentation Survey Reports under Tasks documented:

Restorative: Splint/brace- apply elbow brace, hand splint, and carrot daily to the left hand. The resident was to wear the splint throughout the day for contracture.

R10's EMR under Tasks reviewed from 01/01/24 through 03/31/24 lacked documentation that the splint was applied to R10's left hand.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER: Medicalodges Fort Scott		STREET ADDRESS, CITY, STATE, ZIP CODE: 915 S Horton, Fort Scott, KS 66701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/01/24 at 09:53 AM R10 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room. R10's left contracted left hand laid on his chest with his fingers tightly gripped. R10's left hand did not have a washcloth or carrot in his palm or a splint/brace on his left elbow. R10 stated the staff had not placed a washcloth in his left palm for a long time and said he probably should have one in his hand. On 04/02/24 at 09:55 AM R10 sat slightly reclined in his Broda chair in the common area. R10's contracted left hand lay on his abdomen. R10's left hand did not have a washcloth or carrot in his palm and no splint/brace on his left elbow. On 04/03/24 at 02:30 PM, Certified Nurse Aide (CNA) O stated the dayshift would apply any splints or braces. CNA O stated she had not seen a splint for R10. CNA O stated she had not been told R10 should have a washcloth in his left hand. On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated restorative service was provided depending on staffing levels. LN G stated she was not aware R10 was to wear a splint or brace. On 04/03/24 at 03:33 PM, Administrative Nurse D stated the CNAs would be responsible for ensuring a restorative program was followed. Administrative Nurse D stated the CNAs would also be responsible for ensuring a washcloth was placed in R10's hand. The facility's Restorative Program Policy and Procedure last revised in December 2022 documented the facility would provide ongoing assessments of the residents' functional abilities related to optimal physical functioning, mental capacity, and psychosocial well-being. The facility would identify the residents' potential for the highest practical level of physical functioning, mental abilities, and psychosocial well-being. The facility would develop restorative nursing programs that would be resident-driven also specific and to aid in the design of programs that enable each resident to maintain their highest level of functioning in the areas of physical, mental, and psychosocial wellbeing. The facility failed to ensure R10 received services and treatment for his contractures to prevent an avoidable reduction of ROM. This deficient practice left R10 at risk for further decline and discomfort.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility had a census of 37 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from hazardous materials for eight cognitively impaired independently mobile residents. The facility additionally failed to assess and ensure Resident (R) 25's siderails were mounted safely. This deficient practice placed the affected residents at risk for preventable accidents. Findings Included: - On 04/01/24 at 07:05 AM a walkthrough of the facility was completed. An inspection of the facility's east hallway revealed an unlocked oxygen storage room. An inspection of the room revealed 25 pressurized supplemental oxygen cylinders stored on the racks. The room contained eight smaller pressurized cylinders underneath a shelf. Certified Nurses Aid (CNA) O stated the room should be left secured due to the oxygen canisters and secured the door. An inspection of the north hallway revealed an unsecured beauty shop. The room contained sanitizing chemical wipes. The label of the wipes contained the warning, Keep out of reach of children, hazardous to humans can cause eye irritation, harmful if swallowed. On 04/03/24 at 02:30 PM Licensed Nurse (LN) G stated the oxygen room should be locked at all times to prevent accidents or injuries. She stated cleaning wipes should never be accessible to the residents. On 04/03/24 at 03:00 PM Administrator A stated the facility followed standard of practices for oxygen storage. On 04/03/24 at 03:30 PM Administrative Nurse D stated staff were expected to lock the oxygen storage room and check to ensure it remained locked. She stated any product with the keep out of reach of children warning should never be left out or in an unlocked area. The facility did not have a policy related to safe chemical storage or oxygen storage. The facility failed to ensure a safe environment free from hazardous materials and out of reach from eight cognitively impaired independently mobile residents. This deficient practice placed the affected residents at risk for preventable accidents. 41037 - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Significant Change Minimum Data Set (MDS) dated [DATE] documented severely impaired cognition. The MDS documented R25 was dependent on staff assistance for all activities of daily living. The MDS documented R25 received hospice services during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of eight which indicated moderately impaired cognition. The MDS documented that R25 required substantial to maximum assistance with personal hygiene. The MDS documented R25 received hospice services during the observation period. R25's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/24/23 documented R25 had severe cognitive impairment. R25's Falls Care Area Assessment (CAA) dated 06/24/23 documented he was unsteady during transfers and required extensive assistance. Documented R25 had cognitive impairment which increased his risk for falls and poor safety awareness. Also documented R25 had a history of falls since admission to the facility. R25's Care Plan dated 07/09/21 documented that staff would encourage R25 to change position slowly. R25's plan of care lacked direction for half siderails. R25's EMR under the Assessment tab revealed a Quarterly assessment dated [DATE] that placed R25 at moderate risk for the use of siderails. R25's EMR lacked evidence of alternatives tried before the use of bilateral half siderails. R25's EMR also lacked evidence the risk versus benefits had been explained to R25 and/or his legal representative. The facility was unable to provide documentation upon request. Observation on 04/02/24 at 02:27 PM of R25's left half siderail was loose. The siderail moved freely from side to side (towards the head of the bed then towards the foot of the bed) and when it moved it created approximately a 10-12-inch gap between the rail and the bed frame. noted. Administrative Nurse D was notified and attempted to tighten the siderail with her right hand. Administrative Nurse D stated she was not sure of the frequency of safety checks completed by maintenance on R25's siderails. On 04/03/24 at 07:43 AM R25 lay on his bed with bilateral half siderails pulled up and locked in place. The left half siderail was slightly loose. On 04/02/24 at 02:53 PM Administrative Nurse D stated the maintenance staff checked all the siderails monthly. Administrative Nurse D stated she had care planned R25's siderails. On 04/03/24 at 08:15 AM, Certified Nurse Aide (CNA) N stated R25's left siderail always comes loose and the CNAs just tighten it back up. CNA N stated R25's previous siderails fell off his bed and were replaced with these siderails. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated each resident was assessed for the use of siderails upon admission. LN G stated she would ask the staff how much assistance the new resident required to determine if the new resident was safe to have siderails. LN G stated sometimes the family would be present to ask how much assistance the new resident required to determine if the new admission was safe to utilize siderails. LN G stated the CNAs would know who needed to have a pillow placed between the resident and the siderails for safety. The facility was unable to provide a policy related to the use of siderails. The facility failed to ensure R25's side rails were properly secured, to prevent accidents, injuries, or entrapments. This deficient practice placed R25 at risk of injuries and possible entrapment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample included 12 residents with two residents reviewed for catheters (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and urinary tract infections (UTI infection in any part of the urinary system). Based on observation, record review, and interviews, the facility failed to ensure Resident (R)2 received sanitary catheter care when staff failed to provide R2 education on performing sanitary catheter care and failed to assess R2's ability to self-perform her catheter care. These deficient practices placed the resident at risk for catheter-related complications. Findings included: - R2's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of weakness, acute respiratory failure (occurs when your lungs cannot release enough oxygen you're your blood, which prevents your organs from properly functioning) with hypoxia (hypoxia (inadequate supply of oxygen), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and neuromuscular dysfunction of the bladder(when a person lacks bladder control due to brain, spinal cord or never problems). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented that R2 had an indwelling catheter during the observation period. R2's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 06/06/23 documented R2 was alert, oriented, and requires extensive assistance for toileting. R2 had an indwelling Foley catheter to dependent drainage. R2 used her call light for assistance. She wore a brief for protection and was frequently incontinent of her bowel. R2 was at increased risk for falls, UTI, skin breakdown, and dignity loss. R2's Care Plan dated 05/18/22 documented that staff would provide catheter care every shift. R2's EMR under the Orders tab dated 01/23/23 recorded the following physician orders: Indwelling catheter French number 16, with bulb size of 30. A Nurse's Note dated 03/07/24 documented that R2 had discomfort with a catheter change due to a sore at the urethral (small tubular structure that drains urine from the bladder) opening resembling a canker sore; the surrounding tissue was red and swollen. R2's EMR under the Tasks documentation revealed staff were to provide catheter care each shift. A review of the task documentation revealed staff documented catheter care done three to four times daily. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/24 at 02:48 PM, R2 sat in a wheelchair getting ready to go outside to smoke. Her urine collection bag was covered with a privacy bag and hung on the back handle of the wheelchair. R2 stated she hung the urine bag on the back of her chairs so she could easily reach it when she returned from smoking. R2 stated she did her own catheter care; she stated she wipes it herself with personal wet wipes. She stated staff did not touch her catheter except to change it. She stated she has not received any education on sanitary catheter care or evaluation of her catheter care. On 04/03/23 at 02:20 Certified Nurse's Aide (CNA) O stated she does perineal care regularly with R2 as R2 made had frequent bowel messes but said she does not do catheter care for R2 because R2 did her catheter care. CNA O stated staff was educated about a year and a half ago on catheter care. On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated the catheter care used to be on the nursing treatment records, but it was moved to the CNA tasks. LN G stated she did know R2's catheter care was being performed for R2 because the CNAs were in R2's room for up to 45 minutes sometimes in the evenings. On 04/03/24 at 03:25 PM Administrative Nurse D stated she did know catheter care was a task for the CNAs, but she did not know how R2's self-performance of the catheter care was being monitored. Administrative Nurse D stated she would clarify if education needed to be done with R2. The facility did not provide a policy on request. The facility failed to ensure R2 received sanitary catheter care when staff failed to provide R2 education on performing sanitary catheter care and failed to assess R2's ability to self-perform her catheter care. These deficient practices placed the resident at risk for catheter-related complications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 45668 The facility identified a census of 37 residents. The sample included 12 residents with two reviewed for nutrition. Based on record review, observations, and interviews, the facility failed to obtain accurate weights as ordered by the medical provider to prevent avoidable weight loss for Resident (R)4. This deficient practice placed R4 at risk for complications related to weight loss. Findings Included: - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of cognitive communication deficit, dysphagia (difficulty swallowing), chronic obstructive pulmonary disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, and abnormal weight loss. R4's Admission Minimum Data Assessment (MDS) completed 03/04/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS indicated he weighed 139 pounds (lbs.) upon admission. The MDS indicated he had an enteral feeding tube (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). R4's Feeding Tube Care Area Assessment (CAA) completed 03/08/24 indicated he had an enteral percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach)tube placed before his admission to the facility. The CAA noted the Registered Dietician (RD) will follow R4 to monitor weight loss. R4's Functional Abilities CAA completed 03/08/24 indicated he was alert with confusion and required assistance with bed mobility, transfers, and all his activities of daily living (ADLs). The CAA noted he was able to make his needs known. The CAA noted a care plan will be implemented to assist him with his daily care. R4's Care Plan initiated on 02/28/24 indicated he was at risk for a nutritional decline related to his enteral feeding tube placement and limited food intake. The plan instructed staff to weigh him per his physician's order. The plan instructed staff to check for tube placement and residual volume. The plan instructed staff to ensure the head of R4's bed remained at a 45-degree angle when administering his enteral feeding. R4's EMR under Physician's Orders revealed an order dated 03/04/24 for staff to complete weekly weights every Monday for four weeks. The order was discontinued on 04/01/24. A review of R4's EMR noted his weight upon admission was 143.8 lbs. on 02/28/24. The EMR noted he weighed 139 lbs. on 03/04/24. R4's EMR and physical medical record lacked weights after 03/04/24. On 04/01/24 at 09:00 AM R4 rested in his bed. He had a pressure-reducing mattress and pad in his wheelchair. The head of his bed was elevated above 30 degrees. On 04/02/24 at 01:05 PM, R4 was weighed by staff upon request. He weighed 143.6 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/2024 at 11:34 PM Licensed Nurse (LN) I stated staff weighed the residents per their physician's orders. She stated staff completed the weights and entered the weights into the EMR under the Vitals section. She stated R4 should be weighed weekly due to his enteral diet. On 04/03/24 at 02:10 PM, Certified Nurses Aid (CNA) O stated most residents were on monthly weights, but some would be weighed more often due to their risks or medical needs. She stated the nurse would provide a list of residents to be weighed for the day. She stated that R4 would be weighed more often due to his dietary risks. She stated missed weights or refusals should be noted in the EMR and reported to the nurse. On 04/03/24 at 03:30 PM Administrative Nurse D stated staff were expected to weigh the residents per their orders. She stated that missed weights or refusal should be immediately reported to the nurse and re-attempted later. She stated a progress note should be completed and the weight should be attempted the next day to ensure consistent weight monitoring. She stated she believed R4 was on weekly weights. The facility's provided Weight Assessment and Intervention policy (undated) indicated the facility will monitor weights per physician orders. The policy indicated staff will document and notify the medical provider of changes or missed weights. The facility failed to obtain weights as ordered by the medical provider for R4, who received enteral nutrition. This deficient practice placed R4 at risk for complications related to weight loss.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49634 The facility identified a census of 37 residents. The sample included 12 residents with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure appropriate respiratory care and services for Resident (R)33 and R2. This placed the residents at risk for respiratory complications. Findings included: - R33's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of pulmonary edema (accumulation of extravascular fluid in the lung tissues), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), hypertension (HTN-elevated blood pressure) and weakness. The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of four which indicated severe cognition impairment. The MDS indicated R33 needed assistance with activities of daily living (ADLs). The MDS indicated R33 did not receive oxygen during the observation period. R33's Functional Abilities Care Area Assessment (CAA) dated 12/10/23 documented R33 was unsteady and required staff assistance during transitions. R33 required assistance with dressing, personal hygiene, wheelchair mobility, ambulation with bathing, toileting, bed mobility, and transfers. R33's Care Plan dated 05/16/23 documented R33 needed oxygen to assist with breathing and keep his oxygen levels above 90 percent. R33's EMR under the Orders tab documented the following orders: Apply oxygen as needed to keep oxygen saturation at 90 percent and above dated 01/04/24. Levofloxacin (antibiotic used to treat bacterial infection) dated 03/27/24 give 500 milligrams daily, one tablet, for left-sided pneumonia (inflammation of the lungs). On 04/02/24 at 08:40 AM R33 sat in his wheelchair in the commons area. Staff helped him eat breakfast. R33 received supplemental oxygen via a nasal cannula. On 04/03/24 at 10:45 AM, R33 sat in his wheelchair and did not have an oxygen cannula in his nares. Certified Nurse's Aide (CNA) Q brought R33's oxygen to him with the cannula wrapped around the handle of the oxygen canister. The cannula was not inside a bag or clean container. On 04/03/24 at 11:25 PM, Licensed Nurse (LN) H stated wrapping the nasal cannula around the handle of the oxygen canister was an inappropriate place to store oxygen tubing when oxygen was not in use. She stated staff used to have bags for the oxygen tubing, but the bags fell off, and the tubing was always on the floor. LN H stated wrapping the tubing around the handle worked better. She stated the facility should get straps to wrap them around the handle. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 03:25 PM Administrative Nurse D stated R33's oxygen should be in a container and dated when not in use. The faculty did not provide a policy for oxygen use. The facility failed to ensure R33's oxygen was stored in a sanitary manner while not in use. This placed R33 at increased risk for respiratory complications. - R2's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of weakness, acute respiratory failure (occurs when your lungs cannot release enough oxygen you're your blood, which prevents your organs from properly functioning) with hypoxia (hypoxia (inadequate supply of oxygen), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and neuromuscular dysfunction of the bladder(when a person lacks bladder control due to brain, spinal cord or never problems). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS documented R2 received oxygen during the observation period. R2's Functional Abilities Care Area Assessment (CAA) dated 06/06/23 documented R2 was able to make her wants and needs known and uses her call light for assistance. She requires the assistance of staff for transfers, dressing, and bathing. She used a wheelchair for ambulation. She had a Foley catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) for urine drainage, and she could feed herself independently after the tray was set up by staff. R2's Care Plan dated 02/17/22 documented a potential for respiratory distress due to the diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). After smoking, R2 applies oxygen at two liters via nasal cannula. R2's EMR under the Orders tab lacked a physician order for R2's supplemental oxygen use. On 04/01/24 at 08:10 AM R2 sat in her recliner eating her breakfast. Observation revealed R2 received oxygen via nasal cannula. On 04/02/24 at 08:45 AM, R2 sat in her wheelchair applying her oxygen via nasal cannula. R2 had just returned from going outside to smoke. On 04/03/24 at 03:25 PM, Licensed Nurse (LN) H stated R2 was able to apply her oxygen. LN H was unsure if this needed to be on the EMR. On 04/03/24 at 03:25 PM Administrative Nurse D stated R2 used to have an order for oxygen, but the order had been discontinued in November. Administrative Nurse D stated she would clarify the order for R2's oxygen use. The facility did not have a policy for physician orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure R2 had a physician's order for oxygen use. This placed R2 at increased risk for complications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 37 residents. The sample included 12 residents with one resident reviewed for siderails. Based on observation, record review, and interview, the facility failed to ensure that Resident (R) 25 had documented consent for the use of the siderails, failed to show alternative methods were attempted, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the siderails. This placed the resident and/or representative at risk for uninformed decisions related to the risks and benefits associated with the use of siderails. Findings included: - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit. The Significant Change Minimum Data Set (MDS) dated [DATE] documented severely impaired cognition. The MDS documented R25 was dependent on staff assistance for all activities of daily living. The MDS documented R25 received hospice services during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of eight which indicated moderately impaired cognition. The MDS documented that R25 required substantial to maximum assistance with personal hygiene. The MDS documented R25 received hospice services during the observation period. R25's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/24/23 documented R25 had severe cognitive impairment. R25's Falls Care Area Assessment (CAA) dated 06/24/23 documented he was unsteady during transfers and required extensive assistance. Documented R25 had cognitive impairment which increased his risk for falls and poor safety awareness. Also documented R25 had a history of falls since admission to the facility. R25's Care Plan dated 07/09/21 documented that staff would encourage R25 to change position slowly. R25's plan of care lacked direction for half siderails. R25's EMR under the Assessment tab revealed a Quarterly assessment dated [DATE] that placed R25 at moderate risk for the use of siderails. Review of R25's EMR lacked evidence of alternatives tried before the use of bilateral half siderails. R25's EMR also lacked evidence of documented consent for the use of the siderails and lacked evidence the risk versus benefits had been explained to R25 and/or his legal representative. The facility was unable to provide documentation upon request. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/02/24 at 02:27 PM of R25's left half siderail was loose. The siderail moved freely from side to side (towards the head of the bed then towards the foot of the bed) and when it moved it created approximately a 10-12-inch gap between the rail and the bed frame. noted. Administrative Nurse D was notified and attempted to tighten the siderail with her right hand. Administrative Nurse D stated she was not sure of the frequency of safety checks completed by maintenance on R25's siderails. On 04/03/24 at 07:43 AM R25 lay on his bed with bilateral half siderails pulled up and locked in place. The left half siderail was slightly loose. On 04/03/24 at 08:15 AM, Certified Nurse Aide (CNA) N stated R25's left siderail always comes loose and the CNAs just tighten it back up. CNA N stated R25's previous siderails fell off his bed and were replaced with these siderails. On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated each resident was assessed for the use of siderails upon admission. LN G stated she would ask the staff how much assistance the new resident required to determine if the new resident was safe to have siderails. LN G stated sometimes the family would be present to ask how much assistance the new resident required to determine if the new admission was safe to utilize siderails. LN G stated the CNAs would know who needed to have a pillow placed between the resident and the siderails for safety. The facility was unable to provide a policy related to the use of siderails. The facility failed to ensure that R25 had documented consent for the use of the siderails, failed to show alternative methods were attempted, and failed to ensure the resident and/or responsible party were advised of the risks and/or benefits of the use of the siderails. This placed the resident and/or representative at risk for uninformed decisions related to the risks and benefits associated with the use of siderails.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41037 The facility identified a census of 37 residents. The sample included 12 residents. Based on interview and record review, the facility failed to ensure adequate staffing levels on the weekends to meet the needs of the residents. This placed the residents at risk for impaired mental and physical well-being. Findings included: - A review of the Centers for Medicare and Medicaid Services (CMS) Payroll-Based Journal (PBJ) for Fiscal Year (FY) 2023 Quarter 4 and FY 2024 Quarter 1 revealed the facility triggered for excessively low weekend staffing. On 04/03/24 at 10:15 AM, Resident Council members reported activities rarely occurred on weekends compared to the weekdays. The council reported due to the low staffing in the facility there was no activity person on the weekend. The council reported they would like activities on the weekends, such as bingo or interactive groups on the weekend. On 04/03/24 at 10:37 AM Administrative Staff A stated the weekend staff was low at times related to call-ins and lack of staff. Administrative Staff A stated the weekend staff had improved. On 04/03/24 at 10:51 AM Activities Staff Z reported the facility did not have activities on the weekends. On 04/03/24 at 12:55 PM, Certified Nurses Aid (CNA) Q stated staff used to have activities on the weekends, but now there was only church on Sundays. CNA Q stated most of the residents watched TV on the weekends since that was all there was to do. On 04/03/24 at 02:30 PM, CNA O stated all shifts have low staffing at times. CNA O stated she had been the only CNA on the 2-10 shifts at times and it was hard to complete all her duties. On 04/03/24 at 02:43 PM Licensed Nurse (LN) G stated the facility had low weekend staff; one weekend staffing was lower than the other weekend. LN G stated it was difficult to complete all the nursing duties when there was not even staff to provide care. The facility did not provide a policy related to weekend staffing. The facility failed to ensure adequate staffing levels on the weekends to meet the needs of the residents. This placed the residents at risk for impaired mental and physical well-being. (Refer to F679)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 45668 The facility identified a census of 37 residents. The sample included 12 with one reviewed for significant medication errors. Based on interviews and record reviews, the facility failed to ensure staff possessed the appropriate skills and knowledge to administer Resident (R)30's Midodrine (medication used to increase blood pressure). This deficient practice placed R30 at risk for impaired quality of care. Findings Included: - The Medical Diagnosis section within R30's Electronic Medical Records (EMR) included diagnoses of hypotension (low blood pressure), muscle weakness, major depressive disorder (major mood disorder), and aphasia (condition with disordered or absent language function). R30's Admission Minimum Data Assessment (MDS) completed 03/15/24 noted a Brief Interview for Mental Status (BIMS) assessment was not completed due to severe impairment. The MDS indicated she was dependent on staff assistance for all activities of daily living (ADLs). The MDS indicated she had respiratory services. R30's Communication Care Area Assessment (CAA) completed 03/21/24 indicated she had impaired communication related to her aphasia. The CAA instructed staff to anticipate her needs and provide care as ordered. The CAA indicated care planned interventions will be implemented to reduce the risks related to impaired nutrition, activities of daily living, and pressure injuries. R30's EMR under Physician's Orders revealed an order (started 01/31/24) for staff to administer ten milligrams (mg) of Midodrine by mouth three times daily for hypotension. The parameters instructed staff to hold the medication if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was greater than (>) 100 millimeters of mercury (mmHg). R30's Medication Administration Report (MAR) for March 2024 indicated the medication was given outside of the provided parameters on 37 occasions. A review of the MAR indicated Licensed Nurse (LN) G administered the medication outside the parameters on 20 of the 37 occasions. A review of the facility's in-service schedule indicated no recent medication-based training occurred within February or March of 2024. R30 was unavailable for an interview. On 04/04/24 at 02:30 PM Licensed Nurse (LN) G stated she administered R30's medication without realizing the medication was given for low blood pressure instead of high blood pressure. She stated she did not understand the medication order or indication before giving the medication outside the parameter. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/04/24 at 03:30 PM Administrative Nurse D stated the nursing staff were expected to check the orders before administering the medications. She stated no in-service training related to physician orders or medications has been provided since last year. The facility did not provide a policy related to staff competency, staff training, or performance evaluation. The facility failed to ensure staff possessed the appropriate skills and knowledge to administer R30's Midodrine. This deficient practice placed R30 at risk for impaired quality of care.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 41037 The facility had a census of 37 residents. The sample included 12 residents and five Certified Nurse Aides (CNA) reviewed for performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA Q, hired on 11/24/98 had no yearly performance evaluations upon request. CNA M, hired on 05/14/19 had no yearly performance evaluations upon request. CNA BB, hired on 05/22/20 had no yearly performance evaluations upon request. CNA R, hired on 06/28/22 had no yearly performance evaluations upon request. CNA S, hired on 11/17/97 had no yearly performance evaluations upon request. On 04/02/24 at 04:02 PM Administrative Staff A stated the facility was unable to find any performance evaluations or the required in-service records for the above-mentioned staff. Administrative Staff A stated going forward each department head will conduct the yearly performance evaluation for their staff. On 04/03/24 at 03:30 PM Administrative Nurse D stated she had not conducted any performance evaluations since she had been in her position. She stated she was unable to find any performance evaluations or training for the above-mentioned staff. The facility did not provide a policy related to staff competency, staff training, or performance evaluation. The facility failed to ensure five of the five CNA staff reviewed had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 41037 The facility identified a census of 37 residents. Based on observation, record review, and interviews, the facility failed to retain the daily posted nursing staffing data for the 18 months as required. Findings included: - Review of the daily posted nursing staffing data provided by the facility lacked any posted nursing staffing data for January 2023 (31 days) and February 2023 (28 days). On 04/02/24 at 11:45 AM, Administrative Nurse D stated that all the posted staffing data that was available to be reviewed. Administrative Nurse D stated she was responsible for maintaining the posted nursing data and keeping it in the business office. The facility's Benefits Improvement Protection Act Nursing Staff Posting policy last reviewed in December 2019 documented that when a new daily staff posting form is initiated, the previous form would be removed and given to the business office for filing in the 18-month overflow. The facility failed to retain the daily posted nursing staffing data for the 18 months as required.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 37 residents. The sample included 12 residents. with six residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the need for physician documented rationale for the continued use of the antipsychotic medication for Resident (R) 3 who had a diagnosis of dementia (a progressive mental disorder characterized by failing memory, and confusion). The facility also failed to follow the recommendations of the CP related to R30's Midodrine administration given outside of the physician-provided parameters repeatedly. This deficient practice placed R30 at risk for adverse medication effects. Findings included: - R3's Electronic Medical record (EMR) under the 'Diagnoses tab recorded diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory, and confusion), hallucinations (sensing things while awake that appear to be real, but the mind created) and edema (swelling). R3's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R3 was dependent on staff for most activities of daily living (ADL). The MDS recorded R3 was taking insulin (a hormone that lowers the level of glucose in the blood), a diuretic (medication that promotes the formation and excretion of urine), and an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality). R3's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/10/23 documented R3 was at risk for adverse effects related to the antipsychotic medication she received. R3's Care Plan dated 10/11/21 documented R3 received medications that had a Black Box Warning (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration) and listed those medications which included Lasix (diuretic), and olanzapine (an antipsychotic). The plan dated 01/23/23 documented R3 was at risk for hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) and used insulin to manage her blood sugars. The plan directed staff to administer R3's insulin per the physician's orders and monitor for hyperglycemia and hypoglycemia. R3's EMR recorded the following physician orders: Olanzapine 2.5 mg twice daily for dementia dated 10/06/23. A review of the Monthly Medication Review (MMR) from April 2023 to March 2024 lacked evidence of recommendations for physician documentation for risk versus benefits for the continued use of the antipsychotic medication for R3 with a diagnosis of dementia. (continued on next page)

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F 0756

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

On 04/03/24 at 07:32 AM R3 sat in her wheelchair at the dining room table and drank her coffee.

On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated she did not review the pharmacy MRRs.

On 04/03/24 at 03:30 PM, Administrative Nurse D stated the CP would email the monthly reports to her. Administrative Nurse D stated she would print the reports and deliver them to the physicians for review and signatures. Administrative Nurse D stated the physicians would return the signed MRR to the facility and Administrative Nurse D Stated Administrative Nurse F would review for any new orders or changes, and she would enter the new orders.

The facility's provided Medication Regimen Review and Reporting policy revised 09/2018 indicated the CP will complete monthly medication reviews and provide appropriate recommendations for identified medication concerns. The policy noted the medical director and nursing care center will be notified of immediate concerns affecting resident health and care.

The facility failed to ensure the CP identified and reported an inappropriate indication for R3's olanzapine. This deficient practice placed R3 at risk for unnecessary psychotropic medication and related complications.

45668

- The Medical Diagnosis section within R30's Electronic Medical Records (EMR) included diagnoses of hypotension (low blood pressure), muscle weakness, major depressive disorder (major mood disorder), and aphasia (condition with disordered or absent language function).

R30's Admission Minimum Data Assessment (MDS) completed 03/15/24 noted a Brief Interview for Mental Status (BIMS) assessment was not completed due to severe impairment. The MDS indicated she was dependent on staff assistance for all activities of daily living (ADLs). The MDS indicated she had respiratory services.

R30's Communication Care Area Assessment (CAA) completed 03/21/24 indicated she had impaired communication related to her aphasia. The CAA instructed staff to anticipate her needs and provide care as ordered. The CAA indicated care planned interventions will be implemented to reduce the risks related to impaired nutrition, activities of daily living, and pressure injuries.

R30's EMR under Physician's Orders revealed an order (started 01/31/24) for staff to administer ten milligrams (mg) of Midodrine by mouth three times daily for hypotension. The parameters instructed staff to hold the medication if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was greater than (>) 100 millimeters of mercury (mmHg).

R30's Medication Administration Report (MAR) for March 2024 indicated the medication was given outside of the provided parameters on 37 occasions. A review of the MAR indicated Licensed Nurse (LN) G administered the medication outside the parameters on 20 of the 37 occasions.

R30's Monthly Medication Reviews (MMR) for February 2024 indicated the consulting pharmacist (CP) identified 28 occurrences of her Midodrine medication given outside of parameters. The CP instructed the facility to educate staff on medication administration. The report had no facility response.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R30's MMR for March 2024 indicated the CP noted continued occurrences of the medication given outside of parameters. No facility response was noted on the report. R30's EMR revealed she was admitted to an acute care facility for urosepsis (a condition where a urinary tract infection leads to a systemic infection that spreads throughout the body) on 03/29/24. A review of the facility's in-service schedule indicated no recent medication-based training occurred within February or March of 2024. On 04/04/24 at 03:30 PM Administrative Nurse D stated the CP would fax the recommendation to the facility and she would have to take them the to medical provider for review. She stated the responses would be delayed because she had to wait for the medical provider to return the signed orders and they would have to be put in. She stated R30's medication error should have been communicated to the facility directly to prevent delays or issues with her medical care. The facility's provided Medication Regimen Review and Reporting policy revised 09/2018 indicated the CP will complete monthly medication reviews and provide appropriate recommendations for identified medication concerns. The policy noted the medical director and nursing care center will be notified of immediate concerns affecting resident health and care. The facility failed to follow the recommendations of the CP related to R30's Midodrine administration given outside of the physician-provided parameters repeatedly. This deficient practice placed R30 at risk for adverse medication effects.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 37 residents. The sample included 12 residents with five residents reviewed for unnecessary medication. Based on observation, record review, and interviews, the facility failed to provide adequate pulse monitoring for Resident (R)4's anti-hypertensive beta-blocker (class of medication used to treat high blood pressure). The facility additionally failed to obtain physician-ordered lab results for R3's medication regimen. These deficient practices placed the residents at risk for unnecessary medications and adverse medication effects. Findings Included: - The Medical Diagnosis section within R4's Electronic Medical Records (EMR) included diagnoses of cognitive communication deficit, dysphagia (difficulty swallowing), chronic obstructive pulmonary disorder (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), muscle weakness, and abnormal weight loss. R4's Admission Minimum Data Assessment (MDS) completed 03/04/24 noted a Brief Interview for Mental Status (BIMS) score of nine indicating moderate cognitive impairment. The MDS noted he had hypertension (high blood pressure) and atrial fibrillation (A-fib: rapid, irregular heartbeat). The MDS noted he required substantial to maximal assistance for all his activities of daily (ADLs). R4's Functional Abilities CAA completed 03/08/24 indicated he was alert with confusion and required assistance with bed mobility, transfers, and all his ADLs. The CAA noted he was able to make his needs known. The CAA noted a care plan will be implemented to assist him with his daily care. R4's Care Plan initiated 03/28/24 indicated he took medication with a Black Box Warning (BBW- highest safety-related warning that medications can be assigned by the Food and Drug Administration). The plan noted he took cardiovascular medications and instructed staff to monitor for side effects. The plan noted he took metoprolol (anti-hypertensive beta-blocker medication). R4's EMR under Physician's Orders revealed an order (started 03/12/24) for staff to administer 12.5 milligrams (mg) of metoprolol via his percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) twice daily for chronic A-Fib. The order lacked instructions to monitor R4's pulse before administration. This order was discontinued on 04/03/24. R4's Physician's Order revealed a new order (dated 04/03/24) for staff to administer 12.5mg of metoprolol via his PEG tube twice daily for A-fib. The new order instructed staff to hold the medication if R4's systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was less than (<) 110 millimeters of mercury (mmHg) or pulse (heart rate) < 60 beats per minute (bpm). A review of R4's EMR between 03/12/24 through 04/02/24 revealed no pulse monitoring was completed for the evening dosage of his metoprolol. The EMR indicated his pulse was only completed in the morning. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 07:05 AM Licensed Nurse (LN) G assessed R4's blood pressure and administered his morning medications via enteral administration. On 04/03/24 at 02:30 PM LN G stated R4's pulse and blood pressure should be assessed each time the medication was given. She stated some staff may not be documenting the checks. She stated it should be documented under the Vitals task or directly on the MAR. She stated R4's order was recently changed to include his pulse checks. On 04/03/24 at 03:30 PM Administrative Nurse D stated staff were expected to check pulse before administering Metoprolol each time. She stated the checks were documented in the MAR at the same time the administration was given. The facility's provided Medication Administration policy revised 01/2020 indicated the facility will ensure the proper indication, route, dosage, time/date, and resident while administering medications to residents. The policy noted staff would be provided in-service training on safe administration and were expected to consult with the medical provider and pharmacist if needed. The facility failed to provide adequate pulse monitoring for R4's metoprolol. This deficient practice placed R4 at risk for unnecessary medications and adverse medication effects. 41037 - R3's Electronic Medical record (EMR) under the 'Diagnoses tab recorded diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory, and confusion), hallucinations (sensing things while awake that appear to be real, but the mind created) and edema (swelling). R3's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R3 was dependent on staff for most activities of daily living (ADL). The MDS recorded R3 was taking insulin (a hormone that lowers the level of glucose in the blood), a diuretic (medication that promotes the formation and excretion of urine), and an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality). R3's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/10/23 documented R3 was at risk for adverse effects related to the antipsychotic medication she received. R3's Care Plan dated 10/11/21 documented R3 received medications that had a Black Box Warning (BBW-highest safety-related warning that medications can have assigned by the Food and Drug Administration) and listed those medications which included Lasix (diuretic), and olanzapine (an antipsychotic). The plan dated 01/23/23 documented R3 was at risk for hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar) and used insulin to manage her blood sugars. The plan directed staff to administer R3's insulin per the physician's orders and monitor for hyperglycemia and hypoglycemia. R3's EMR recorded the following physician orders: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a Complete Blood Count (CBC-laboratory blood test), Comprehensive Metabolic Panel (CMP-laboratory blood test), Lipid panel (blood test), Hemoglobin A1C (blood test), and urine analysis every three months dated to start on 10/01/23. Lasix 40 milligrams (mg) by mouth one time daily for high blood pressure dated 10/11/21. Potassium chloride 20 milliequivalents (meq) one tablet daily for health maintenance dated 10/11/21. Glipizide (oral medication used to manage blood sugar levels) 10 mg twice daily for DM dated 07/11/23. Novolog (fast-acting insulin) per sliding scale twice daily for DM dated 11/15/22. R25's EMR lacked evidence of the results from the laboratory tests ordered. The facility was unable to provide the results as requested. On 04/03/24 at 07:32 AM R3 sat in her wheelchair at the dining room table and drank her coffee. On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated the charge nurse would fill out physician-ordered laboratory tests. LN G said it would depend on which physician placed that order as to which laboratory would provide the service. LN G stated the order should be listed on the Treatment Administration Record (TAR). On 04/03/24 at 03:30 PM, Administrative Nurse D stated she did not know why R3's laboratory tests had not been completed as ordered in October 2023. Administrative Nurse D stated the physician was notified and a laboratory test had been obtained in January 2024. The facility was unable to provide a policy related to following a physician's order. The facility failed to ensure the physician's order was followed for R3's laboratory tests to monitor for high-risk medications. This deficit practice placed R3 at risk of adverse side effects and unnecessary medications.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 37 residents. The sample included 12 residents with five residents reviewed for unnecessary medications. Based on observation, record review, and interview the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R)3's olanzapine (antipsychotic medication). This placed the resident at risk for unnecessary psychotropic (alters perception, mood, consciousness, cognition, or behavior) medications and related complications. Findings included: - R3's Electronic Medical record (EMR) under the 'Diagnoses tab recorded diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), dementia (a progressive mental disorder characterized by failing memory, and confusion), hallucinations (sensing things while awake that appear to be real, but the mind created) and edema (swelling). R3's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R3 was dependent on staff for most activities of daily living (ADL). The MDS recorded R3 was taking insulin (a hormone that lowers the level of glucose in the blood), a diuretic (medication that promotes the formation and excretion of urine), and an antipsychotic (class of medications used to treat major mental conditions that cause a break from reality). R3's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/10/23 documented R3 was at risk for adverse effects related to the antipsychotic medication she received. R3's Care Plan dated 10/11/21 documented R3 received medications that had a Black Box Warning (BBW-highest safety-related warning that medications can be assigned by the Food and Drug Administration) and listed olanzapine. The plan dated 10/04/22 documented R3 received therapeutic medications to help regulate her emotions and thoughts. The plan documented R3 received olanzapine for her dementia. R3's EMR recorded the following physician orders: Olanzapine 2.5 mg twice daily for dementia dated 10/06/23. R3's clinical record lacked evidence of a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of olanzapine. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 07:32 AM R3 sat in her wheelchair at the dining room table and drank her coffee. On 04/03/24 at 02:43 PM, Licensed Nurse (LN) G stated she was not sure what would be an acceptable indication for the use of antipsychotic medication. LN G stated she thought a resident with dementia and behaviors should receive an antipsychotic medication to treat their behaviors. On 04/03/24 at 03:30 PM, Administrative Nurse D stated a resident with a diagnosis of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) would be an appropriate indication for the use of an antipsychotic medication. Administrative Nurse D stated the facility was working with the physicians to reduce the use of antipsychotic medications. The facility's Behavior Management and Psychotropic Medications policy documented that residents would be assessed for the appropriate diagnosis and target behaviors related to psychotropic medication use and off-label use of medication prescribed that affects brain activity. The plan of care would address individualized focus, goals, and interventions directed toward managing the resident's targeted behaviors and non-pharmacological interventions. The facility failed to ensure an appropriate indication for use or the required physician documentation for R3's continued use of olanzapine. This placed the resident at risk for unnecessary psychotropic medication effects.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45668 The facility identified a census of 37 residents. The sample included 12 with one reviewed for significant medication errors. Based on interviews and record reviews, the facility failed to prevent a significant medication error for Resident (R)30 when staff administered Midodrine (medication used to increase blood pressure) outside of the physician-provided parameters repeatedly. This deficient practice placed R30 at risk for adverse medication effects. Findings Included: - The Medical Diagnosis section within R30's Electronic Medical Records (EMR) included diagnoses of hypotension (low blood pressure), muscle weakness, major depressive disorder (major mood disorder), and aphasia (condition with disordered or absent language function). R30's Admission Minimum Data Assessment (MDS) completed 03/15/24 noted a Brief Interview for Mental Status (BIMS) assessment was not completed due to severe impairment. The MDS indicated she was dependent on staff assistance for all activities of daily living (ADLs). The MDS indicated she had respiratory services. R30's Communication Care Area Assessment (CAA) completed 03/21/24 indicated she had impaired communication related to her aphasia. The CAA instructed staff to anticipate her needs and provide care as ordered. The CAA indicated care plan interventions will be implemented to reduce the risks related to impaired nutrition, activities of daily living, and pressure injuries. R30's EMR under Physician's Orders revealed an order (started 01/31/24) for staff to administer ten milligrams (mg) of Midodrine by mouth three times daily for hypotension. The parameters instructed staff to hold the medication if systolic blood pressure (SBP-relating to the phase of the heartbeat when the heart muscle contracts and pumps blood from the chambers into the arteries) was greater than (>) 100 millimeters of mercury (mmHg). A review of R30's Medication Administration Report (MAR) for March 2024 indicated the medication was given outside of the provided parameters on 37 occasions. A review of the MAR indicated Licensed Nurse (LN) G administered the medication outside the parameters on 20 of the 37 occasions. A review R30's Monthly Medication Reviews (MMR) for February 2024 indicated the consulting pharmacist (CP) identified 28 occurrences of her Midodrine medication given outside of parameters. The CP instructed the facility to educate staff on medication administration. The report had no facility response. A review R30's MMR for March 2024 indicated the CP noted continued occurrences of the medication given outside of parameters. No facility response was noted on the report. A review of the facility's in-service schedule indicated no recent medication-based training occurred within February or March of 2024. R30 was unavailable for an interview. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/04/24 at 02:30 PM Licensed Nurse (LN) G stated she administered R30's medication without realizing the medication was given for low blood pressure instead of high blood pressure. She stated she did not understand the medication order or indication before giving the medication outside the parameter. On 04/04/24 at 03:30 PM Administrative Nurse D stated the nursing staff were expected to check the orders before administering the medications. She stated daily reviews of the MAR should be completed by each shift to ensure errors or medication concerns were identified and corrected. She stated no in-service training related to physician orders or medications has been provided since last year. The facility's provided Medication Administration policy revised 01/2020 indicated the facility will ensure the proper indication, route, dosage, time/date, and resident while administering medications to residents. The policy noted staff would be provided in-service training on safe administration and were expected to consult with the medical provider and pharmacist if needed. The facility failed to prevent a significant medication error for R30 who received Midodrine outside of the physician-provided parameters on repeated occasions. This deficient practice placed R30 at risk for adverse medication effects.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41037 The facility identified a census of 37 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, and a failed to describe the services and equipment provided to Resident (R) 25 by hospice. This deficient practice created a risk for missed or delayed services and impaired care for R25. Findings included: - R25's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), hypertension (HTN-elevated blood pressure), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and cognitive communication deficit. The Significant Change Minimum Data Set (MDS) dated [DATE] documented severely impaired cognition. The MDS documented R25 was dependent on staff assistance for all activities of daily living. The MDS documented R10 had difficulty with his hearing and did not wear hearing aids during the observation period. The MDS documented R25 received hospice services during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of eight which indicated moderately impaired cognition. The MDS documented that R25 required substantial to maximum assistance with personal hygiene. The MDS documented R10's hearing was adequate with the assistance of his hearing aids. The MDS documented R25 received hospice services during the observation period. R25's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 06/24/23 documented R25 had severe cognitive impairment. R25's Care Plan dated 06/12/23 documented the facility would coordinate R25's care and services with the hospice provider. The plan of care directed the facility staff to communicate with the hospice provider for any ongoing treatment plans to help maintain optimum care to meet R25's needs. The plan of care dated 11/03/23 documented that hospice would provide a bath on Wednesday and Thursday, and the facility would bathe R25 on Monday and Friday. The plan of care also documented the hospice nurse would come on Tuesday and Thursday. A review of the communication book provided by the hospice revealed R25 was admitted to hospice services on 06/12/23. The hospice communication book lacked documentation of the recent services provided by hospice. The last documentation was dated 03/15/24. On 04/02/24 at 08:07 AM R25 sat in his wheelchair at the dining room table without his hearing aids. One of his table mates attempted to talk to R25. R25 was unable to hear what was said to him. R25 stated he could not hear; his hearing aids had been lost. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/24 at 0930 AM Licensed Nurse (LN) G stated she was unable to locate recent documentation of services provided by hospice. LN G stated the hospice had her sign electronically and she was not sure what happened after that. On 04/03/24 at 10:43 AM LN G stated she had asked the hospice provider how their documentation was placed into the hospice communication book. LN G stated the hospice provider would print off the care provided every two weeks and place a copy into the hospice communication book. On 04/03/24 at 02:30 PM, Certified Nurse Aide (CNA) O stated she would ask the nurse which residents received hospice services. CNA O stated she was not sure if there was any hospice information on the plan of care, but that would be a good place to have what was provided by hospice, along with what equipment was provided by hospice. On 04/03/24 at 02:33 PM, Administrative Nurse D stated that R25's plan of care should include all the services and equipment provided by the hospice provider. Administrative Nurse D stated the hospice provider's visits should be placed in the hospice communication for the facility staff to review if needed. The facility was unable to provide a policy related to hospice services. The facility failed to ensure a communication process was implemented, which included how the communication would be documented between the facility and the hospice provider, and a failed to describe the services and equipment provided to R25 by hospice. This deficient practice created a risk for missed or delayed services and impaired care for R25.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 45668 The facility identified a census of 37 residents. The sample included 12 residents. Based on record review, observations, and interviews, the facility failed to ensure adequate infection control standards related to following enhanced barrier precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employs targeted gown and glove use during high contact care), laundry services, and sanitary care practices. his deficient practice placed the residents at risk for infectious diseases. Findings Included: - The facility identified it was completing ongoing exposure testing for COVID-19 (highly contagious, potentially life-threatening respiratory virus) but had no COVID-19-positive residents in the facility. A review of Resident (R)2's Electronic Medical Record (EMR) indicated she had a Foley catheter (a tube inserted into the bladder to drain urine into a collection bag). Her EMR lacked indication she was on enhanced barrier precautions. A review of R4's EMR indicated he had a percutaneous endoscope gastrostomy tube (PEG-a tube inserted through the wall of the abdomen directly into the stomach) for enteral nutrition (provision of nutrients through the gastrointestinal tract when the resident cannot ingest, chew, or swallow food). His EMR lacked indication he was on enhanced barrier precautions. A review of R10's EMR indicated he had a Foley catheter. His EMR lacked indication he was on enhanced barrier precautions. R14's EMR indicated he had a recovering surgical wound. It lacked indication he was on enhanced barrier precautions. A review of R188's EMR indicated he had a Foley catheter. His EMR lacked indication he was on enhanced barrier precautions. On 04/01/24 at 07:05 AM an inspection of R2, R4, R10, R14, and R188's rooms indicated enhanced barrier precautions were not implemented for the residents. Their rooms lacked signage and required personal protective equipment (PPE) readily available outside the room. On 04/01/24 at 07:20 AM the north hallway clean linen room door was left open with multiple sheets on the bottom shelf touching the floor. The north hallway ice machine ice storage basin was left open with melted ice and the ice scoop was left inside. On 04/01/24 at 07:50 AM R2's nasal oxygen tubing laid on the floor in her room. On 04/01/24 at 11:40 AM a trash bag of soiled incontinence briefs sat on the floor in the hallway by R2's door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/24 at 11:44 AM Housekeeping Staff U transported an uncovered cart containing clean linen down the 100 (north) Hallway. On 04/01/24 at 03:42 PM, R14's oxygen tubing was wrapped around the handle of his oxygen canister. Certified Nurse's Aide (CNA) P was transporting the canister and tubing to the dining room for R14. On 04/02/24 at 02:17 PM Housekeeping Staff U pushed a metal cart in the hallway uncovered with resident's clean clothing. Housekeeping Staff U stated she had never been trained or informed that clean clothing needed to be covered in the hall. On 04/03/24 at 07:43 AM CNA N and CNA M completed peri-care on R25. While completing peri-care on R25, CNA N completed multiple glove changes without performing hand hygiene in between glove changes. She stated trash and linens should never touch the floor due to contamination risks. On 04/03/24 at 02:00 PM, CNA O stated the facility had not educated her on enhanced barrier precautions and she was not sure if the facility had any residents currently that were supposed to be on them. She stated staff were expected to complete hand hygiene in between changing PPE and gloves. She stated oxygen tubing should be stored in a clean bag to prevent cross-contamination. On 04/03/24 at 02:44 PM, Licensed Nurse (LN) G stated she was not aware of enhanced barrier precautions and that the facility had not educated staff on the new requirements. She stated she was not aware if any of the residents were on them. She stated oxygen tubing should be stored in a clean bag when not in use. She stated hand hygiene is to be completed in between glove changes. On 04/03/24 at 03:30 PM Administrative Nurse D stated she was aware of the new enhanced barrier precautions requirements, but the facility had not implemented or educated staff on them. She stated staff was expected to complete hand hygiene before, during, and after care with residents. She stated staff were regularly provided in-service education on hand hygiene and prevention of infections. A review of the facility's Infection Management Process policy revised 11/2023 indicated the facility will ensure the prevention of infectious diseases by ensuring appropriate hand hygiene completion, education, and sanitary care practices that limit exposure among residents. The policy lacked information related to enhanced barrier precautions. The facility failed to ensure adequate infection control standards related to following EBP, laundry services, and sanitary care practices. This deficient practice placed the residents at risk for infectious diseases.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 37 residents. The sample included 12 residents with five reviewed for pneumococcal (type of bacterial infection), and influenza (highly contagious viral infection immunizations. Based on record review and interviews, the facility failed to provide consent, declination, or documentation of ineligibility for Resident (R)2, R19, and R33's pneumococcal vaccinations. This deficient practice placed the residents at risk for complications related to pneumococcal diseases. Findings Included: - On 04/02/24 at 10:03 AM a review was completed related to pneumococcal and influenza vaccinations for R2, R7, R19, and R33. R2's Electronic Medical Record (EMR) indicated she was admitted to the facility on [DATE]. The EMR indicated she refused the Prevnar 13 (07/2017) and Pneumovax 23 (09/2018) vaccinations. The EMR indicated she received an unidentified pneumococcal vaccination from the Kansas Department of Health and Environment (KDHE) on 12/05/22. The EMR lacked consent, declination, or documentation of ineligibility for her offered pneumococcal vaccinations. The EMR lacked documentation related to the education provided and the risks associated with the vaccinations ordered. R19's EMR indicated she was admitted to the facility on [DATE]. The EMR lacked documentation indicating her pneumococcal immunization status. The EMR lacked consent, declination, or documentation of ineligibility for her pneumococcal vaccinations. The EMR lacked documentation related to the education provided and the risks associated with the vaccinations ordered. R33's EMR indicated he admitted to the facility on [DATE]. The EMR lacked documentation indicating his pneumococcal immunization status. The EMR lacked consent, declination, or documentation of ineligibility for his pneumococcal vaccinations. The EMR lacked documentation related to the education provided and the risks associated with the vaccinations ordered. On 04/02/24 at 03:05 PM Administrator A stated the facility was unable to find the missing immunization documentation due to changes in staffing. On 04/32/24 at 03:30 PM Administrative Nurse D stated the facility was behind on their vaccinations. She stated she was developing a system to better track and audit needed immunization documentation. She stated the residents should be screened upon admission or re-admission by the admitting nurse for needed vaccinations. She stated the facility provides clinical days for immunizations. She stated the facility was working on a plan to track the new recommendations for the pneumococcal immunization requirements. The facility's provided Vaccination/Immunizations policy revised 02/2023 indicated the facility would screen and offer influenza and pneumococcal immunizations based upon the Centers for Disease Control (CDC) recommendations. The policy indicated the facility will track each resident's immunization status and provide documentation in the electronic medical record. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide consent, declination, or documentation of ineligibility for R2, R19, and R33's pneumococcal vaccinations. This deficient practice placed the residents at risk for complications related to pneumonia.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45668 The facility identified a census of 37 residents. The sample included 12 residents with five reviewed for COVID-19 (highly contagious viral infection) immunizations. Based on record review and interviews, the facility failed to provide consent, declination, or documentation of ineligibility for Resident (R)3's COVID-19 immunizations. This deficient practice placed the residents at risk for complications related to COVID-19. Findings Included: - On 04/02/24 at 10:03AM a review was completed related to COVID-19 immunization for R2, R3, R7, R19, and R33. R3's EMR indicated she was admitted to the facility on [DATE]. The EMR lacked documentation indicating she received or was offered COVID-19 immunizations. The EMR indicated she had no COVID-19 vaccinations. The EMR lacked consent, declination, or documentation of ineligibility for her COVID-19 vaccinations. The EMR lacked documentation related to the education provided and the risks associated with the vaccinations ordered. On 04/02/24 at 03:05 PM Administrator A stated the facility was unable to find the missing immunization documentation due to changes in staffing. On 04/32/24 at 03:30 PM Administrative Nurse D stated the facility was behind on their vaccinations. She stated she was developing a system to better track and audit needed immunization documentation. She stated the residents should be screened upon admission or re-admission by the admitting nurse for needed vaccinations. She stated the facility provides clinical days for immunizations. She stated the facility was working on a plan to track the new recommendations for the pneumococcal immunization requirements. The facility's COVID-19 for Residents policy indicates the facility will follow the CDC guidelines related to immunizations and document in the resident's EMR the offering, administration, and declination of the vaccination provided. The facility failed to provide consent, declination, or documentation of ineligibility for R3's COVID-19 vaccinations. This deficient practice placed R3 at risk for complications related to infectious diseases.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Fort Scott	915 S Horton Fort Scott, KS 66701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 45668 The facility identified a census of 37 residents. The sample included 12 residents. Based on records review, interviews, and observations, the facility failed to provide effective pest control so that the facility was free from pests. This placed the residents at increased risk for impaired comfort and disease. Finding Included: - An inspection of the facility's Pest Siting log indicated that cockroaches were last seen in the facility on 07/07/23 around the north hall soiled utility room. The pest control log indicated the facility contracted a company to spray monthly. The log indicated the last pest control treatment was in March 2024. On 04/01/24 at 07:01 AM a walkthrough of the facility was completed. An inspection of an unlocked shower room labeled Handicapped Women's Bathroom (north hall) revealed a large number of cockroaches crawling along the shower, toilet, cabinets, sink ceiling, and bathtub in the room. On 04/03/24 at 02:30 PM, Licensed Nurse (LN) G stated she was aware the facility had large numbers of cockroaches. She stated staff reported the north hall bathroom was infested with them. She stated the facility has had a problem with cockroaches for the past seven years and couldn't get rid of them. She stated the company comes out monthly to treat the facility, but it never gets rid of them. On 04/03/24 at 03:30 PM Administrative Nurse D stated it's an old facility and hard to get rid of the roaches. She stated the pest control company comes monthly to spray but the cockroaches were still there. The facility did not have a policy related to pest control. The facility failed to provide effective pest control so that the facility was free from pests. This placed the residents at increased risk for impaired comfort and disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175258	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Medicalodges Fort Scott		STREET ADDRESS, CITY, STATE, ZIP CODE 915 S Horton Fort Scott, KS 66701	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 41037 The facility had a census of 37 residents. The sample included 12 residents and five Certified Nurse Aides (CNAs) reviewed for 12 hours of required in-service training. Based on record review and interview, the facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for inadequate care. Findings included: - A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA Q, hired on 11/24/98 had no hours of in-service training recorded. CNA M, hired on 05/14/19 had no hours of in-service training recorded. CNA BB, hired on 05/22/20 had no hours of in-service training recorded. CNA R, hired on 06/28/22 had no hours of in-service training recorded. CNA S, hired on 11/17/97 had no hours of in-service training recorded. On 04/02/24 at 04:05 PM Administrative Staff A stated the facility was unable to find any performance evaluations or the required in-service records for the above-mentioned staff. On 04/03/24 at 03:30 PM Administrative Nurse D stated she had not conducted any performance evaluations since she had been in her position. She stated she was unable to find any performance evaluations or training for the above-mentioned staff. The facility did not provide a policy related to staff competency, staff training, or performance evaluation. The facility failed to ensure five of the five CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for inadequate care.