STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175522	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Great Bend	1401 Cherry Lane Great Bend, KS 67530

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 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** 41713 The facility identified a census of 37 residents. The sample included 12 residents with five residents sampled for accidents. Based on observation, record review, and interview, the facility failed to ensure an environment free from accident hazards when the facility failed to secure fully pressurized supplemental oxygen cylinders in a safe, locked area, and out of reach of the five cognitively impaired independently mobile residents. The facility additionally failed to ensure interventions were put in place for 22 of Residents (R) 33's 41 falls. This deficient practice placed the residents at risk for preventable accidents, falls, and injuries. Findings included: - On 07/22/24 at 08:02 AM a walkthrough of the facility revealed an unsecured oxygen storage room. The room contained 38 fully pressurized supplemental oxygen cylinder tanks stored in floor racks. The room had a numerical keypad on the entry door. No facility staff was in the storage room area. The room's keypad door auto-locked when pulled closed. On 07/24/24 at 08:18 AM Certified Nurse Aide (CNA) O stated that the oxygen storage room should always remain locked to ensure a resident did not wander into the room. On 07/24/24 at 09:26 AM Licensed Nurse (LN) G stated the oxygen storage room should always be locked due to the wandering residents in that facility. LN G stated the door had a keypad lock. On 07/24/24 at 09:37 AM Administrative Nurse D stated the oxygen storage room should always remain locked unless a staff member was accessing the room. On 07/24/24 at 09:39 AM Administrative Nurse E stated on the morning of 07/22/24 a staff member was preparing a resident to go to the doctor and had just obtained a new oxygen bottle for that resident and must have mistakenly not gotten the door closed all the way when they exited the room. Administrative Nurse E stated staff have been educated to ensure the door was closed and always locked. On 07/24/24 at 12:15 PM Administrative Staff A stated the facility did not have a specific policy related to the oxygen storage room but that it was just a standard of care. The facility, upon request, did not provide a policy for oxygen cylinder storage. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure an environment free from accident hazards when the facility failed to secure pressurized medical oxygen cylinder tanks in a safe, locked area, and out of reach of the five cognitively impaired, independently mobile residents. This deficient practice placed the residents at risk for preventable accidents and injuries. 26768 - R33's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), chronic pain, anxiety disorder (a mental or emotional disorder characterized by apprehension, uncertainty and irrational fear), persistent mood disorders and insomnia (inability to sleep). R33's Quarterly Minimum Data Set (MDS), dated [DATE], documented short- and long-term memory problems with moderately impaired decision-making, physical and verbal behaviors, and rejection of care. The MDS documented R33 required partial assistance for eating and was dependent on staff for all other activities of daily living (ADL) and mobility. The MDS documented R33 had two or more non-injury falls, two or more minor injury falls since the last MDS assessment, and received an antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), an antianxiety (class of medications that calm and relax people) and a hypnotic (a class of medications used to induce sleep) medications. R33's Fall Care Plan, dated 06/10/24, stated R33 was at risk for falls due to wandering and psychotropic (alters mood or thought) medications. The care plan directed staff to encourage R33 to wait for assistance from staff before attempting to stand up. Staff were to ensure R33 had a high-low bed, and R33 needed to have it lower when he was in bed. The plan recorded he would sit on the floor to move things around and try to fix things. If no staff member witnessed him putting himself on the floor, nurses would treat the incident as a fall, including assessing him and completing neurological checks per protocol. Staff were to ensure he wore appropriate shoes and nonslip footwear. The plan directed to ask the pharmacist and physician to monitor R33's medications on an ongoing basis and to place the call light within his reach. The plan further directed the following interventions related to falls: Fall on 12/21/23 Assist R33 to the restroom before bed at night. Fall on 12/29/23 Encourage R33 to sit or lie down when he appears to be tired. Fall on 12/29/23 Encourage R33 to use a wheelchair if he appears to be weak or groggy, or if he was using the handrails in the hallways to support himself. Fall on 12/30/23 Keep the bathroom light or another light on in R33's room. Fall on 01/02/24 Encourage R33's to help staff with tasks to reduce wandering. Fall on 01/03/24 R33 was moved to a room closer to the nurse's station on 01/13/24. Fall on 01/06/24 Staff to set the brakes on his wheelchair when R33 is stationary. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall on 01/10/24 Encourage R33 to sit near the nurse's station after dinner until he is ready to go to bed. Fall on 01/14/24 Staff should help lower the resident to the floor during a fall to avoid injury. Fall on 01/15/24 Encourage R33 to stand up straight if he is leaning while walking. Fall on 01/24/24 Assist R33 in putting non-skid socks back on when he takes them off. Fall on 01/25/24 Staff should pick up anything that R33 drops right away, and prompt him not to do it himself. Fall on 01/28/24 Place anti-roll-back bars on R33's wheelchair to prevent it from rolling backwards. Fall on 02/12/24 Staff were to assist R33 to get up and sit at the nursing station or dining room for meals. Please get him up early when possible. Fall on 02/01/24 Medication review with changes by the psychiatric provider. Fall on 02/04/24 Medication review with changes completed on 02/15/24 due to a fall on 02/13/24. Fall on 05/06/24 Staff were to offer R33 food at night when he is restless and trying to get out of bed. Fall on 05/23/24 A scoop mattress was placed on R33's bed to remind him not to roll over too far. Fall on 04/02/24 When R33's family leaves after a visit, staff need to monitor him on one or bring him to the nurse's desk where he can be seen by staff. R33's EMR documented 41 falls since admission on 12/04/23 and no care plan revision indicating new interventions for 22 of those falls. The Fall Note, dated 07/22/24 at 10:48 AM, documented that R33 sat upright in his wheelchair in a well-lit uncluttered walkway in the back hall next to the nurse's station. There was some commotion when the resident was observed falling to the floor from a standing position. On 07/22/24 at 01:35 PM, observation revealed R33 sat in a wheelchair by the nurse's desk. R33 wore non-skid socks and his feet rested on the floor. R33 appeared relaxed. At 01:43 PM, R33 continued to sit. He had his head down, and his eyes closed. Certified Medication Aide (CMA) R placed footrests on his wheelchair and took him to his room. Observation revealed a maintenance issue in his room, so the staff took him back to the nurse's desk area and gave him a snack. On 07/24/24 at 09:15 AM, Administrative Nurse E stated R33 had a lot of repetitive causes of falls due to attempting to stand. Administrative Nurse E verified the facility had not developed interventions and updated R33's plan of care with each fall to prevent further falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Risk Management policy, dated 11/2023, stated with each event, the charge nurse would update the resident's care plan with a new intervention to prevent further occurrence of the event. The facility failed to identify and implement effective interventions to prevent further falls for R33, placing the resident at risk for further falls and injury.

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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** 26768 The facility had a census of 37 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure the Consultant Pharmacist (CP) identified and notified the facility and physician of the numerous times staff administered two blood pressure medications to Resident (R) 21 when the physician order indicated the medications should have been held (not administered) in April, May, and June 2024. This deficient practice placed R21 at risk for unintended results from medications. Findings included: - R21's Electronic Medical Record (EMR) recorded a diagnosis of hypertension (HTN-elevated blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition. The MDS documented R21 required set-up assistance for meals and was dependent on staff for all other activities of daily living (ADL) and mobility. R21's Medication Care Plan, dated 07/22/24, directed staff to administer R21's medications at about the same time each day and check the blood pressure before giving the medications. The care plan stated the pharmacist and physician were to review medications. The Physician Order, dated 04/04/24, directed staff to administer amlodipine (blood pressure lowering medication)10 milligram (mg) daily and hold for a blood pressure less than 100/65 millimeters (mm) of Mercury (Hg) if either number is lower. The Physician Order, dated 04/04/24, directed staff to administer benazepril (blood pressure lowering medication),10 mg daily, and hold for blood pressure less than 100/65 mm/Hg if either number is lower. R21's Medication Administration Record (MAR) revealed the following: April 5-30, 2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter 11 times. In May 2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter 16 times. In June 2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter 10 times. On July 1-23,2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter eight times. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Pharmacist Consultant Medication Regimen Reviews for April, May, and June 2024 lacked notes regarding the administration of benazepril and amlodipine when the blood pressures were out of the physician-ordered parameters. On 07/23/24 at 07:38 AM, observation revealed Certified Medication Aide (CMA) R obtained R21's blood pressure while he was seated in the dining room and then administered medications including amlodipine, 10 mg and benazepril, 10 mg to R21. CMA R crushed the pills and mixed them with water before giving them to R21. On 07/23/24 at 12:47 PM, Licensed Nurse (LN) G verified the CMA should not have administered the amlodipine and benazepril due to the out-of-parameter blood pressure. LN G verified the numerous times staff administered the two medications, April through the current time, that staff should have held the two medications. On 07/24/24 at 09:15 AM, Administrative Nurse E verified the facility's Consultant Pharmacist had not informed the facility of the ongoing medication errors. The facility's Medication Regimen Review (MRR) and Reporting policy, dated 2007, stated the medication regimen review included a review of the medical records in order to prevent, identify, report, and resolve medication-related problems, errors, or other irregularities. The findings would be communicated to the director of nursing and the medical director. Resident-specific MRR recommendations and findings would be documented and acted upon by the nursing care center and or the physician. The facility failed to ensure the CP identified and notified the facility and physician of the numerous times staff administered two blood pressure medications to R21 outside the physician ordered parameters. This deficient practice placed R21 at risk for unintended results from medications.

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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** 26768 The facility had a census of 37 residents. The sample included 12 residents with five reviewed for unnecessary drugs. Based on observation, interview, and record review the facility failed to hold Resident (R) 21's blood pressure medication per the physician ordered blood pressure parameters. This deficient practice placed R21 at risk for unnecessary medications and related complications. Findings included: - R21's Electronic Medical Record (EMR) recorded a diagnosis of hypertension (HTN-elevated blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of four, indicating severely impaired cognition. The MDS documented R21 required set-up assistance for meals and was dependent on staff for all other activities of daily living (ADL) and mobility. R21's Medication Care Plan, dated 07/22/24, directed staff to administer R21's medications at about the same time each day and check the blood pressure before giving the medications. The care plan stated the pharmacist and physician were to review medications. The Physician Order, dated 04/04/24, directed staff to administer amlodipine (blood pressure lowering medication)10 milligram (mg) daily and hold for a blood pressure less than 100/65 millimeters (mm) of Mercury (Hg) if either number is lower. The Physician Order, dated 04/04/24, directed staff to administer benazepril (blood pressure lowering medication),10 mg daily, and hold for blood pressure less than 100/65 mm/Hg if either number is lower. R21's Medication Administration Record (MAR) revealed the following: April 5-30, 2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter 11 times. In May 2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter 16 times. In June 2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter 10 times. On July 1-23,2024, staff administered amlodipine and benazepril when R21's blood pressure was lower than the physician-ordered parameter eight times. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/23/24 at 07:38 AM, observation revealed Certified Medication Aide (CMA) R obtained R21's blood pressure while he was seated in the dining room and then administered medications including amlodipine, 10 mg and benazepril, 10 mg to R21. CMA R crushed the pills and mixed them with water before giving them to R21. On 07/23/24 at 12:47 PM, Licensed Nurse (LN) G verified the CMA should not have administered the amlodipine and benazepril due to the out-of-parameter blood pressure. LN G verified the numerous times staff administered the two medications, April through the current time, that staff should have held the two medications. On 07/24/24 at 09:15 AM, Administrative Nurse E verified the ongoing medication error. Upon request, the facility did not provide a medication administration policy. The facility failed to hold R21's blood pressure medication per the physician ordered blood pressure parameters. This deficient practice placed R21 at risk for unnecessary medications and related complications.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 41713 The facility had a census of 37 residents. The sample included 12 residents. Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent. This deficient practice placed Resident (R) 21 at risk for significant medication errors and resulted in a facility medication error rate of 7.69 percent (%) placing all residents who received medication at risk for medication errors. Findings included: - The Physician Order, dated 04/04/24, directed staff to administer amlodipine (blood pressure lowering medication)10 milligram (mg) daily and hold for a blood pressure less than 100/65 millimeters (mm) of Mercury (Hg) if either number is lower. The Physician Order, dated 04/04/24, directed staff to administer benazepril (blood pressure lowering medication),10 mg daily, and hold for blood pressure less than 100/65 mm/Hg if either number is lower. On 07/23/24 at 07:38 AM, observation revealed Certified Medication Aide (CMA) R obtained R21's blood pressure while he was seated in the dining room and then administered medications including amlodipine, 10 mg and benazepril, 10 mg to R21. CMA R crushed the pills and mixed them with water before giving them to R21. On 07/23/24 at 07:45 AM, R21's EMR documented a blood pressure of 128/60 mmHg. On 07/23/24 at 12:28 PM, CMA R verified the physician's orders to hold the amlodipine and benazepril for a blood pressure less than 100/65 and verified she should not have administered those medications that morning. On 07/23/24 at 12:47 PM, Licensed Nurse (LN) G verified the CMA should not have administered the amlodipine and benazepril due to the out-of-parameter blood pressure. Upon request, the facility did not provide a policy related to medication errors. The facility failed to administer medications with a less than five percent error rate placing R21 at risk for significant medication errors and resulting in a 7.69 % error rate. This placed all residents who received medications at risk for complications related to medication errors.

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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. 37450 The facility had a census of 37 residents. Based on record review and interview, the facility failed to ensure staff completed the required 12-hour in-service education for Certified Nurse Aide (CNA) N and CNA T, who were all employed by the facility for at least one year. This deficient practice placed the residents at risk of decreased quality of care. Findings included: - A review of the facility's 12-hour annual in-service documentation for five certified staff members who had been employed at the facility for at least one year revealed the following: CMA T lacked dementia care training. CNA N lacked had only completed three of the required 12 in-service hours. On 07/24/24 at 09:37 AM Administrative Nurse D reported the facility utilized an electronic education system for the required education. She confirmed the above staff did not have the required education topics and /or hours. Upon request, the facility did not provide a policy for required services. The facility failed to ensure required topics and 12-hours in-service education for CMA S and T and CNA N, which placed the residents at risk for decreased quality of care.