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	175157	A. BUILDING _____ B. WING _____	C 04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ANDOVER	621 W 21ST, PO BOX 100 ANDOVER, KS 67002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations # KS00140239, KS00140085, KS00139981, KS00139154, KS00138559 and KS00138565. The 2567 was electronically sent to the facility on 05/01/19.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		

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

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when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 89 residents with 28 selected for sample review. Based on observation, interview, and record review, the facility failed to ensure timely notification for 2 of the 28 residents' (#35 and 29) reviewed. The facility failed to notify the physician in a timely manner when resident #35 experienced a significant decline and required hospitalization. Additionally, the facility failed to notify resident # 29 of a medication change.

Findings included:

- Resident #35's admission MDS (minimum data set), dated 3/26/19, indicated long and short-term memory impairment with varied levels of consciousness, which lacked evidence of any

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behaviors. The assessment identified the resident required extensive assistance of staff for ADLs (activities of daily living) with supervision needed for eating and used a wheelchair for mobility.

The 3/29/19 CAA (care area assessment) for communication, identified the resident experienced a CVA with aphasia, therefore used hand gestures and yelling to get staff attention. The resident was usually able to make his/her needs/wants known.

The resident's care plan, dated 3/26/19, instructed staff in the provision of cares including:

Observe for shortness of breath, choking, labored respirations, lung congestion.
Observe and report changes in usual routine, sleep patterns, decrease in functional ability, decreased ROM (range of motion), withdrawal or resistance to care.
Encourage fluids during the day to promote prompted voiding.
Observe for sign/symptoms of UTI (urinary tract infection) including, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color.
Observe for symptoms of respiratory distress and report to MD (medical doctor), respirations, pulse oximetry (monitoring the oxygen level in the blood), increased heart rate, restlessness, diaphoresis (sweating), headache, lethargy (fatigue, apathetic, stupor or sluggishness), confusion, atelectasis (collapsing of the lung), hemoptysis (coughing up blood), cough, pleuritic (pain in the lung/chest area) pain, accessory muscle use, and skin color.
Provide oxygen. (No further instructions were

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provided)

Review of the physician orders included 02 (oxygen) via NC (nasal cannula) at 2 Liters to maintain 02 saturation at 90% or above, ordered 3/22/19.

Review of nursing notes, prior to the resident's significant decline and admission to the hospital included the following relevant notes:

On 3/29/19 at 9:05 AM, the PCP gave orders for lab tests of BMP (basic metabolic profile) and CBC (complete blood count). The staff informed the resident's responsible party of the residents increased behaviors and lab orders.

On 3/29/19 at 12:55 PM, the nurse documented the resident refused to have a laboratory test drawn and planned to attempt again on 4/1/19. The facility failed to notify the PCP of the resident's refusal.

On 4/2/19 at 8:50 AM, the staff documented the resident was to have labs drawn, however, refused to allow the lab technician to draw blood. The staff notified the family and the PCP of the resident's refusal. No new orders received.

On 4/3/19 at 9:38 AM, the staff documented the resident's vital signs and noted the resident remained on skilled nursing services for a recent hospitalization related to pneumonia. Respirations even and unlabored with lung sounds clear to auscultation (hearing breath sounds, usually with the use of a stethoscope). The staff documented the resident was incontinent of bowel and bladder with perineal care provided by staff and the resident required

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extensive assistance of 2 staff for transfers. Resident able to feed self with set-up assistance, cueing, and exhibited right sided weakness related to a history of CVA.

On 4/3/19 at 2:27 PM, the staff documented the lab called to report a critical potassium level of 6.1. Staff notified the PCP, who indicated the plan to await the results of the remainder of the labs to determine further treatment. The resident's responsible party was made aware of the lab result and the PCP feedback.

On 4/4/19 at 2:09 AM, the staff documented the resident transferred to the hospital for further treatment, per family request. The nurse further noted receiving a report that the resident's lab results were previously sent to the PCP for consideration and orders. During rounds [at 11PM-12AM], the staff reported the resident did not respond to staff as normal. The staff then notified the nurse who upon assessment found the resident to be congested in the chest and gurgling. Staff suctioned the resident with lots of residue obtained from suction and the gurgling ceased. The facility staff failed to notify the PCP. The family arrived at the facility and wanted the resident sent to the hospital. While assessing the resident, the family called and spoke to the PCP, after which family handed the cellphone to this nurse who received an order to send the resident to the hospital. Family called 911 and the resident then left with EMS (emergency medical services) at 2:05 AM.

A review of the resident's hospital records (4/4-4/6/19) identified per admission information, dated 4/4/19, the resident was admitted with severe sepsis, likely due to aspiration pneumonia

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and UTI (urinary tract infection).

An interview, on 4/10/19 at 2:30 PM, with the resident's responsible party/family member reported that he/she visited the facility on Sunday, 3/31/19 and the resident was in his/her bed, at approximately 2:00 PM. The family member/responsible party spoke with licensed nursing staff Y regarding the resident and requested a return call with results of the resident's completed laboratory work and the doctor's response. The family reported he/she received an initial call, however, then did not receive a further call and believed the labs must not have been returned to the facility. During the night, around 11PM, the facility nurse called and indicated the resident was not good and might not have long left. The family reported he/she would arrive as soon as possible. Around 1AM, the family member arrived at the facility. Upon entering the resident's room, the family member found the resident laying in the bed, gasping for air, gray in color and stated his/her tongue was almost black. Family called out immediately for help and licensed nursing staff Z, came to the resident's room. The family member determined the staff failed to call the PCP and took it upon him/her self to call the PCP. While the nurse spoke to the PCP, the family member called EMS from the resident's room phone. The family reported upon EMS's arrival they placed a mask with a bag on it for the resident as his/her oxygen level remained at 74%.

On 4/10/19 at 2:28 PM, administrative nursing staff C, reported the expectation of the nurses for a resident with high potassium level, to monitor the resident closely, perhaps as often as hourly or at least every 2 hours, including vital signs with

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each assessment and would expect the nurse to notify the physician of significant changes in condition.

On 4/15/19 at 6:00 AM, licensed nursing staff Z reported that night he/she checked on the resident every couple of hours and around midnight, called the family. The nurse indicated that at that time, the nurse had just checked the resident's vitals and found the oxygen level abnormally low, and with oxygen available in the room the nurse placed it on the resident. The nurse further reported, earlier the nurse suctioned the resident, due to the congestion and gurgling, and at that time the 02 level was okay (did not recall the percentage). After suctioning the resident, the oxygen level dropped and then he/she decided to call the family, however, had not notified the physician, at that time.

The facility policy, dated 3/07, for Alert Charting, documented the need for increased monitoring of residents with a change of condition or status. Documentation must focus on noted deterioration/improvement in resident conditions and include notification to the physician and responsible party.

The facility failed to ensure notification to the physician at the time of this residents declining health status, and refusal for laboratory testing.

- Resident # 29's annual MDS (minimum data set), dated 11/30/18, evidenced the resident with a BIMS (brief interview of mental status) score of 15, indicating intact cognition and without any mood or behavioral concerns. The resident needed extensive assistance for most ADLs

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(activities of daily living).

A quarterly MDS, dated 3/2/19, lacked changes in the BIMS and mood/behavior assessments however, indicated improvements in ADLs to supervised and independent.

The ADL CAA (care area assessment), dated 12/5/18, identified the resident as alert and verbalized needs/concerns. The resident required some assistance by nursing staff with ADLs and transfers.

The resident's care plan, dated 12/26/18, included instruction to the staff in interaction with the resident. The care plan failed to identify any interventions related to counselling for this resident, as he/she requested.

Review of the physician orders dated 3/4/19 identified the PCP increased the resident's Duloxetine HCL DR (delayed release), 30 mg (milligrams) capsules, give 90 mg, by mouth daily for depression. This order was increased from 60 mg daily.

On 4/9/19 at 9:48 AM the resident reported being unaware of any recent medication changes. The clinical record lacked evidence of the resident being informed of the increase in his/her anti-depressant.

On 4/10/19 at 10:22 AM, administrative nursing staff C reported that this resident was frequently unhappy about his medications. The facility recently provided additional training and education to the nursing staff regarding documentation and refusals, of medications.

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F 580	Continued From page 8 The facility policy, dated 5/2018, for Alert Charting, indicated the charge nurse on shift when the condition developed would initiate the charting for medication changes and document in the clinical record regarding the change and notification to responsible party/family. The facility failed to ensure the alert and oriented resident, who received a medication change, received notification of the medication change.	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		

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Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 89 residents with 3 selected for sample review regarding neglect. Based on interview and record review, the facility failed to ensure an alleged incident of neglect, resulting in the hospitalization of a resident, was reported to the state agency, as required.

Findings included:

- Resident #35's, ECR (electronic clinical record) recorded diagnoses of pneumonitis (inflammation and/or infection of the lungs) due to inhalation of food and vomit, sepsis (systemic infection of the blood), a history of falling, Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), type II with diabetic neuropathy (pain/tingling and/or numbness in the extremities), hypertension (high blood pressure), dementia (progressive mental disorder characterized by failing memory, and confusion) with behavioral disturbance, dysphagia (swallowing difficulty) and aphasia (disordered or absent language function) following cerebrovascular accident (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The admission MDS (minimum data set), dated 3/26/19, indicated long and short-term memory impairment with varied levels of consciousness, which lacked evidence of any behaviors. The

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assessment identified the resident required extensive assistance of staff for ADLs (activities of daily living) with supervision needed for eating and used a wheelchair for mobility.

The 3/29/19 CAA (care area assessment) for communication, identified the resident experienced a CVA with aphasia, therefore used hand gestures and yelling to get staff attention. The resident was usually able to make his/her needs/wants known.

The resident's care plan, dated 3/26/19, instructed staff in the provision of cares including:
Observe and report PRN (as needed) any sign/symptom of dysphagia including pocketing (holding foods in the cheeks and crevices of the mouth), choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or appearing concerned during meals.
Observe for shortness of breath, choking, labored respirations, lung congestion.
Observe and report changes in usual routine, sleep patterns, decrease in functional ability, decreased ROM (range of motion), withdrawal or resistance to care.
Encourage fluids during the day to promote prompted voiding.
Observe for sign/symptoms of UTI (urinary tract infection) including, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color.
Observe for symptoms of respiratory distress and report to MD (medical doctor), respirations, pulse oximetry (monitoring the oxygen level in the blood), increased heart rate, restlessness, diaphoresis (sweating), headache, lethargy (fatigue, apathetic, stupor or sluggishness),

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confusion, atelectasis (collapsing of the lung), hemoptysis (coughing up blood), cough, pleuritic (pain in the lung/chest area) pain, accessory muscle use, and skin color.
Provide oxygen. (No further instructions were provided)

Review of the physician orders included 02 (oxygen) via NC (nasal cannula) at 2 Liters to maintain 02 saturation at 90% or above, ordered 3/22/19.

On 4/3/19 at 9:38 AM, the staff documented the resident's vital signs and noted the resident remained on skilled nursing services for a recent hospitalization related to pneumonia. The staff noted the resident climbed out of the low bed and onto a mat beside the bed. The staff assisted the resident back into bed and the resident began throwing items off the bedside table. Respirations even and unlabored with lung sounds clear to auscultation (hearing breath sounds, usually with the use of a stethoscope). The staff documented the resident was incontinent of bowel and bladder with perineal care provided by staff and the resident required extensive assistance of 2 staff for transfers. Resident able to feed self with set-up assistance, cueing, and exhibited right sided weakness related to a history of CVA.

On 4/3/19 at 2:27 PM, the staff documented the lab called to report a critical potassium level of 6.1. Staff notified the PCP, who indicated the plan to await the results of the remainder of the labs to determine further treatment. The resident's responsible party was made aware of the lab result and the PCP feedback.

On 4/3/19 at 10:05 PM, the staff documented a

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blood sugar of 285 mg/dl. (Staff later reported in his/her witness statement this occurred around 8:00 PM, however, was documented at 10:05 PM.)

On 4/4/19 at 2:09 AM, the staff documented the resident transferred to the hospital for further treatment, per family request. During rounds [at 11PM-12AM], the staff reported the resident did not respond to staff as normal. The staff then notified the nurse who upon assessment found the resident to be congested in the chest and gurgling. Staff suctioned the resident with lots of residue obtained from suction and the gurgling ceased. The family arrived at the facility and wanted the resident sent to the hospital. While assessing the resident, the family called and spoke to the PCP, after which family handed the cellphone to this nurse who received an order to send the resident to the hospital. Family called 911 and the resident then left with EMS (emergency medical services) at 2:05 AM (approximately 2 hours after the staff noted the resident with respiratory concerns).

The nursing notes as well as the entire medical record lacked evidence of any vital signs or other assessments of the resident's condition throughout the evening/night shift.

A review of the resident's hospital records (4/4-4/6/19) identified the following concerns: Per admission information, dated 4/4/19, the resident was admitted with severe sepsis, likely due to aspiration pneumonia and UTI (urinary tract infection). Other diagnoses included acute hypoxic (inadequate supply of oxygen) respiratory failure, acute kidney injury, hyperkalemia, pyuria (the presence of WBC in the urine; usually an

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indicator of UTI), diabetes mellitus, type II, history of cerebrovascular accident, seizures (violent involuntary series of contractions of a group of muscles), coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart), chronic pain, hypertension, thrombocytosis (abnormal increase in the number of platelets in the blood) and chronic dysphasia. The resident was brought to ER (emergency room) and found severely septic. After completing a culture (blood test), the resident began a broad-spectrum ABT (antibiotic). Diagnosis of a UTI, with purulent (milky, cloudy) urine. The resident presented with acute hypoxic (lack of enough oxygen) respiratory failure, likely secondary to aspiration pneumonia. The resident was intubated upon arrival and admitted to the ICU (intensive care unit). Acute hyperkalemic (a high level of potassium) and with acute kidney injury (the inability of the kidneys to adequately process toxins from the body through the urine) were found with pulmonology (respiratory services) and nephrology (kidney services) consulted. The resident was found with severe metabolic encephalopathy (a brain disease altering brain function), and despite being on the vent did not require any sedation. The resident lacked purposeful movement and would only withdraw to pain.

An interview, on 4/10/19 at 2:30 PM, with the resident's responsible party/family member reported that he/she visited the facility on Sunday, 3/31/19 and the resident was in his/her bed, at approximately 2:00 PM. The resident's uneaten lunch tray was on the overbed table, but there was not any fluid on it. The visitor noted the resident was very lethargic and was grayish in color. The visitor went to get the resident some

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water to go with his/her meal and spoke with licensed nursing staff Y regarding the resident. The nurse stated he/she would get the resident some thickened water from the kitchen and brought a pitcher of water back to the family member. The family further reported he/she did get the resident to take a few bites of food, and the resident drank the entire pitcher of thickened water. The family indicated the resident was tired and kept falling back asleep between bites. Licensed nursing staff Y reported to the family the resident refused to have labs drawn earlier that day. The family stated, he/she did not know how that could be, as the resident was so weak. The family member reported he/she told the nurse if the facility could not get the lab drawn to send the resident to the hospital. The family reported the facility did call again, on 4/3/19 and indicated the resident had a critical high level of potassium and the facility notified the PCP, however, the PCP did not want to treat this until the remainder of the lab results were available for review. The nurse indicated those labs would be back later that day and the PCP would be notified, at that time. The caller requested to be notified, as well. The family reported he/she did not receive a further call and believed the labs must not have been returned to the facility. During the night, around 11PM, the facility nurse called and indicated the resident was not good and might not have long left. The family reported he/she would arrive as soon as possible. Around 1AM, the family member arrived at the facility. Upon entering the resident's room, the family member found the resident laying in the bed, gasping for air, gray in color and stated his/her tongue was almost black. Family called out immediately for help and licensed nursing staff Z, came to the resident's room. When asking the nurse about the

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resident's status, the nurse reported the last time he/she checked the oxygen saturation was at 95%. The family asked for it to be rechecked and the nurse left to get the equipment needed. When the nurse placed the monitor on the resident, the reading was 73%. The caller indicated he/she wanted to know what the PCP had said about the resident's status and the nurse reported to the family that the resident was at the end of life, was not sick and that nothing more could be done for him/her. The family member instructed the nurse to put oxygen on the resident, and the nurse then placed the oxygen tube under his/her nose. The family member reported he/she had the PCP's cell number and he/she then called the PCP and told him/her what was going on with the resident. The PCP then asked to speak to the nurse and gave orders to transport the resident to the hospital. While the nurse spoke to the PCP, the family member called EMS from the resident's room phone. The family reported upon EMS's arrival they placed a mask with a bag on it for the resident as his/her oxygen level remained at 74%. The family reported the resident passed away at the hospital after being placed on a ventilator to aid his/her breathing, but that the resident was septic with a bad infection. The family further indicated that upon return from the 2nd most recent hospitalization, that he/she was always to be supervised and/or provided assistance when eating and that was not what the family observed.

On 4/10/19 at 2:28 PM, administrative nursing staff C, reported on the morning of 4/4/19 he/she received a call around 2PM and licensed nursing staff Z indicated that the family came into the facility and that the resident's condition was declining and needed hospitalization. The PCP

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received notification earlier in the day regarding a high potassium level, however, the PCP did not want to treat the resident's high potassium until reviewing the remainder of the laboratory results. The staff further indicated that licensed nursing staff Y notified the PCP around 5:00 PM that same day of the other lab results and the PCP did not have any further orders. Staff C's expectation of the nurses for a resident with high potassium level, to monitor the resident closely, perhaps as often as hourly or at least every 2 hours, including vital signs with each assessment. Staff C further noted, when he/she spoke with nurse Z, after the resident went to the hospital, he/she did not say anything about how often he/she checked/monitored/assessed the resident that evening, nor did staff C ask about the evening shift assessments. Staff C indicated prior to today (4/10/19) the staff failed to review the incident/event and the staff were unaware of the lack of documentation of assessments through the shift, leading up to the resident requiring suctioning and EMS transport.

The facility policy dated 2/2018 for Protection of Residents: Reducing the Threat of Abuse and Neglect: included the policy and practice of the facility was that all residents would be protected from all types of abuse, neglect, misappropriation of resident property and exploitation. Furthermore, when an incident or suspected incident of resident neglect is reported, an investigation will occur.

The facility failed to report an incident of suspected neglect to the state agency, as required, when the facility staff failed to provide adequate and timely assessment of the resident, who was hospitalized at the family's insistence

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F 609	Continued From page 17 and subsequently passed at the hospital.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility reported a census of 89 residents with 3 selected for sample review regarding neglect. Based on interview and record review, the facility failed to ensure an alleged incident of neglect, resulting in the hospitalization of a resident, was thoroughly investigated by the facility. Findings included: - Resident #35's, ECR (electronic clinical record) recorded diagnoses of pneumonitis (inflammation and/or infection of the lungs) due to inhalation of food and vomit, sepsis (systemic infection of the	F 610		

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blood), a history of falling, Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), type II with diabetic neuropathy (pain/tingling and/or numbness in the extremities), hypertension (high blood pressure), dementia (progressive mental disorder characterized by failing memory, and confusion) with behavioral disturbance, dysphagia (swallowing difficulty) and aphasia (disordered or absent language function) following cerebrovascular accident (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The admission MDS (minimum data set), dated 3/26/19, indicated long and short-term memory impairment with varied levels of consciousness, which lacked evidence of any behaviors. The assessment identified the resident required extensive assistance of staff for ADLs (activities of daily living) with supervision needed for eating and used a wheelchair for mobility.

The 3/29/19 CAA (care area assessment) for communication, identified the resident experienced a CVA with aphasia, therefore used hand gestures and yelling to get staff attention. The resident was usually able to make his/her needs/wants known.

The resident's care plan, dated 3/26/19, instructed staff in the provision of cares including: Observe and report PRN (as needed) any sign/symptom of dysphagia including pocketing (holding foods in the cheeks and crevices of the mouth), choking, coughing, drooling, holding food

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in mouth, several attempts at swallowing, refusing to eat, or appearing concerned during meals.
Observe for shortness of breath, choking, labored respirations, lung congestion.
Observe and report changes in usual routine, sleep patterns, decrease in functional ability, decreased ROM (range of motion), withdrawal or resistance to care.
Encourage fluids during the day to promote prompted voiding.
Observe for sign/symptoms of UTI (urinary tract infection) including, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color.
Observe for symptoms of respiratory distress and report to MD (medical doctor), respirations, pulse oximetry (monitoring the oxygen level in the blood), increased heart rate, restlessness, diaphoresis (sweating), headache, lethargy (fatigue, apathetic, stupor or sluggishness), confusion, atelectasis (collapsing of the lung), hemoptysis (coughing up blood), cough, pleuritic (pain in the lung/chest area) pain, accessory muscle use, and skin color.
Provide oxygen. (No further instructions were provided)

Review of the physician orders included 02 (oxygen) via NC (nasal cannula) at 2 Liters to maintain 02 saturation at 90% or above, ordered 3/22/19.

On 4/3/19 at 9:38 AM, the staff documented the resident's vital signs and noted the resident remained on skilled nursing services for a recent hospitalization related to pneumonia. The staff noted the resident climbed out of the low bed and onto a mat beside the bed. The staff assisted the resident back into bed and the resident began

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throwing items off the bedside table. Respirations even and unlabored with lung sounds clear to auscultation (hearing breath sounds, usually with the use of a stethoscope). The staff documented the resident was incontinent of bowel and bladder with perineal care provided by staff and the resident required extensive assistance of 2 staff for transfers. Resident able to feed self with set-up assistance, cueing, and exhibited right sided weakness related to a history of CVA.

On 4/3/19 at 2:27 PM, the staff documented the lab called to report a critical potassium level of 6.1. Staff notified the PCP, who indicated the plan to await the results of the remainder of the labs to determine further treatment. The resident's responsible party was made aware of the lab result and the PCP feedback.

On 4/3/19 at 10:05 PM, the staff documented a blood sugar of 285 mg/dl. (Staff later reported in his/her witness statement this occurred around 8:00 PM, however, was documented at 10:05 PM.)

On 4/4/19 at 2:09 AM, the staff documented the resident transferred to the hospital for further treatment, per family request. The nurse further noted receiving a report that the resident's lab results were previously sent to the PCP for consideration and orders. During rounds [at 11PM-12AM], the staff reported the resident did not respond to staff as normal. The staff then notified the nurse who upon assessment found the resident to be congested in the chest and gurgling. Staff suctioned the resident with lots of residue obtained from suction and the gurgling ceased. The family arrived at the facility and wanted the resident sent to the hospital. While

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assessing the resident, the family called and spoke to the PCP, after which family handed the cellphone to this nurse who received an order to send the resident to the hospital. Family called 911 and the resident then left with EMS (emergency medical services) at 2:05 AM (approximately 2 hours after the staff noted the resident with respiratory concerns).

The nursing notes as well as the entire medical record lacked evidence of any vital signs or other assessments of the resident's condition throughout the evening/night shift.

A review of the resident's hospital records (4/4-4/6/19) identified the following concerns: Per admission information, dated 4/4/19, the resident was admitted with severe sepsis, likely due to aspiration pneumonia and UTI (urinary tract infection). Other diagnoses included acute hypoxic (inadequate supply of oxygen) respiratory failure, acute kidney injury, hyperkalemia, pyuria (the presence of WBC in the urine; usually an indicator of UTI), diabetes mellitus, type II, history of cerebrovascular accident, seizures (violent involuntary series of contractions of a group of muscles), coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart), chronic pain, hypertension, thrombocytosis (abnormal increase in the number of platelets in the blood) and chronic dysphasia. The resident was brought to ER (emergency room) and found severely septic. After completing a culture (blood test), the resident began a broad-spectrum ABT (antibiotic). Diagnosis of a UTI, with purulent (milky, cloudy) urine. The resident presented with acute hypoxic (lack of enough oxygen) respiratory failure, likely secondary to aspiration pneumonia. The resident

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was intubated upon arrival and admitted to the ICU (intensive care unit). Acute hyperkalemic (a high level of potassium) and with acute kidney injury (the inability of the kidneys to adequately process toxins from the body through the urine) were found with pulmonology (respiratory services) and nephrology (kidney services) consulted. The resident was found with severe metabolic encephalopathy (a brain disease altering brain function), and despite being on the vent did not require any sedation. The resident lacked purposeful movement and would only withdraw to pain.

An interview, on 4/10/19 at 2:30 PM, with the resident's responsible party/family member reported that he/she visited the facility on Sunday, 3/31/19 and the resident was in his/her bed, at approximately 2:00 PM. The resident's uneaten lunch tray was on the overbed table, but there was not any fluid on it. The visitor noted the resident was very lethargic and was grayish in color. The visitor went to get the resident some water to go with his/her meal and spoke with licensed nursing staff Y regarding the resident. The nurse stated he/she would get the resident some thickened water from the kitchen and brought a pitcher of water back to the family member. The family further reported he/she did get the resident to take a few bites of food, and the resident drank the entire pitcher of thickened water. The family indicated the resident was tired and kept falling back asleep between bites. Licensed nursing staff Y reported to the family the resident refused to have labs drawn earlier that day. The family stated, he/she did not know how that could be, as the resident was so weak. The family member reported he/she told the nurse if the facility could not get the lab drawn to send the

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resident to the hospital. The family reported the facility did call again, on 4/3/19 and indicated the resident had a critical high level of potassium and the facility notified the PCP, however, the PCP did not want to treat this until the remainder of the lab results were available for review. The nurse indicated those labs would be back later that day and the PCP would be notified, at that time. The caller requested to be notified, as well. The family reported he/she did not receive a further call and believed the labs must not have been returned to the facility. During the night, around 11PM, the facility nurse called and indicated the resident was not good and might not have long left. The family reported he/she would arrive as soon as possible. Around 1AM, the family member arrived at the facility. Upon entering the resident's room, the family member found the resident laying in the bed, gasping for air, gray in color and stated his/her tongue was almost black. Family called out immediately for help and licensed nursing staff Z, came to the resident's room. When asking the nurse about the resident's status, the nurse reported the last time he/she checked the oxygen saturation was at 95%. The family asked for it to be rechecked and the nurse left to get the equipment needed. When the nurse placed the monitor on the resident, the reading was 73%. The caller indicated he/she wanted to know what the PCP had said about the resident's status and the nurse reported to the family that the resident was at the end of life, was not sick and that nothing more could be done for him/her. The family member instructed the nurse to put oxygen on the resident, and the nurse then placed the oxygen tube under his/her nose. The family member reported he/she had the PCP's cell number and he/she then called the PCP and told him/her what

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was going on with the resident. The PCP then asked to speak to the nurse and gave orders to transport the resident to the hospital. While the nurse spoke to the PCP, the family member called EMS from the resident's room phone. The family reported upon EMS's arrival they placed a mask with a bag on it for the resident as his/her oxygen level remained at 74%. The family reported the resident passed away at the hospital after being placed on a ventilator to aid his/her breathing, but that the resident was septic with a bad infection. The family further indicated that upon return from the 2nd most recent hospitalization, that he/she was always to be supervised and/or provided assistance when eating and that was not what the family observed.

On 4/10/19 at 2:28 PM, administrative nursing staff C, reported on the morning of 4/4/19 he/she received a call around 2PM and licensed nursing staff Z indicated that the family came into the facility and that the resident's condition was declining and needed hospitalization. The PCP received notification earlier in the day regarding a high potassium level, however, the PCP did not want to treat the resident's high potassium until reviewing the remainder of the laboratory results. The staff further indicated that licensed nursing staff Y notified the PCP around 5:00 PM that same day of the other lab results and the PCP did not have any further orders. Staff C's expectation of the nurses for a resident with high potassium level, to monitor the resident closely, perhaps as often as hourly or at least every 2 hours, including vital signs with each assessment. Staff C further noted, when he/she spoke with nurse Z, after the resident went to the hospital, he/she did not say anything about how often he/she checked/monitored/assessed the resident

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F 610	Continued From page 25 that evening, nor did staff C ask about the evening shift assessments. Staff C indicated prior to today (4/10/19) the staff failed to review the incident/event and the staff were unaware of the lack of documentation of assessments through the shift, leading up to the resident requiring suctioning and EMS transport. The facility policy dated 2/2018 for Protection of Residents: Reducing the Threat of Abuse and Neglect: included the policy and practice of the facility was that all residents would be protected from all types of abuse, neglect, misappropriation of resident property and exploitation. Furthermore, when an incident or suspected incident of resident neglect is reported, an investigation will occur. The facility failed to conduct a thorough investigation of an incident of suspected neglect, when the facility staff failed to provide adequate and timely assessment of the resident, who was hospitalized at the family's insistence and subsequently passed at the hospital.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		

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(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 89 residents with 5 selected for sample review. Based on observation, interview, and record review, the facility failed to develop individualized care plans for 3 of 28 residents reviewed for care planning. The lack of individualized care plans affected resident #29 for dietary needs, pain management, and grief counselling, # 49 for dietary needs,

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allergies and pain, and # 35 for oxygen use.

Findings included:

- Resident # 29's annual MDS (minimum data set), dated 11/30/18, evidenced the resident with a BIMS (brief interview of mental status) score of 15, indicating intact cognition and lacked identification of any mood or behavioral concerns. The resident needed extensive assistance for most ADLs (activities of daily living), received scheduled pain medications only without the use of PRN or non-pharmacological interventions. The resident expressed daily verbal complaints of pain. The assessment identified the resident without chewing swallowing problems, on a therapeutic diet and indicated unknown weight loss or gain.

A quarterly MDS, dated 3/2/19, lacked changes in the resident's cognition, mood and behaviors, and identified an improvement in the resident's ADL needs from extensive to supervised or independence. The assessment identified the resident received scheduled pain meds only with the resident experiencing pain frequently. The assessment lacked changes in the dietary assessment from the prior assessment.

The ADL CAA (care area assessment), dated 12/5/18 included the resident was alert and verbalized needs/concerns, and required some assistance with ADLs and transfers.

The nutritional CAA, dated 12/4/18, included the resident consumed meals independently with a good appetite. The staff monitor the resident's weight routinely. The resident triggered due to diuretic use and potential weight loss.

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The psychotropic drug use CAA, dated 12/4/18, included the resident being alert and able to verbalize needs/concerns and at risk for depression secondary to nursing facility placement. Staff monitor behaviors every shift the resident was followed medically by PCP (primary care physician).

The Pain CAA, dated 12/4/18, included the resident required extensive assist with ADLS and transfers and was at risk for pain secondary to problems with teeth and lower extremity edema. The resident's pain is controlled by the current pain medication regimen. Pain assessment are completed by licensed nursing staff routinely and the PCP followed the resident for medical concerns.

A nutritional assessment, dated 1/3/18, identified a diet order of regular diet with diet condiments.

On 1/19/18 the resident expressed concern regarding increased blood sugars and requested menus with limited concentrated carbohydrates. A recommendation of changing to a CCHO diet was made.

On 6/2/18 the staff documented the resident on a CCHO (concentrated carbohydrate-controlled diet) with diet condiments.
On 6/18/18 a follow-up diet order and communication noted to include an allergy to seafood and peanuts.
On 12/20/18 a quarterly nutrition assessment identified the resident stayed in his/her room for meals, was able to feed self, and often ordered double portions. The resident's skin remained intact with a CCHO diet with diet condiments of

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regular texture. The resident made own choices of food intake and talked about making improved diet choices to reduce caloric intake, however, does not follow through when ordering meals, choosing to have extra portions.

The resident's care plan, dated 12/26/18, lacked instructions to the staff on the resident's desired and physician ordered dietary needs. Additionally, the care plan lacked instruction to the staff regarding the residents increased grief and request for counselling, as well as pain control interventions.

Regarding diet:
On 4/9/19 at 9:48 AM, the resident sat on the edge of the bed, beginning breakfast. Per review of the resident's dietary order, the resident ordered 2 bowls of cheerios, 2 cartons of milk, 2 sausage patties and 4 slices of bacon, yogurt and chocolate milk. The kitchen sent: bacon, sausage, 1 whole milk, 1 2% milk, and 2 bowls of frosted flakes (resident reported yesterday he got fruit loops when he had ordered cheerios -- Been out of cheerios for several days.)
On 4/9/19 at 1:30 PM, the staff delivered the resident's lunch tray to the resident's room. The resident reported, the kitchen filled the order properly including corned beef, potatoes with cabbage, cauliflower, and grapes.
On 4/10/19 at 8:30 AM the resident sat on the edge of the bed, with a tray in front of the resident. The resident ordered for breakfast, per review of the order slip: pancakes, bacon, sausage, 2% milk, chocolate milk, tomato juice, 1 bowl of cheerios and yogurt. The kitchen sent: 8-10 sausage links, 2 biscuits, 2 bowls of fruit loops, 1 2% milk, 1 chocolate milk, and a yogurt.
9:20 AM, the resident requested pain medication

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from the CNA.

Interview, on 4/9/19 at 9:48 AM, with the resident reported he/she had several concerns about his/her treatment and care at the facility. The resident reported he/she addressed all these concerns with the staff and the facility was aware of the concerns. The resident reported that for over a year since coming to live at the facility, they had failed to offer diet condiments, particularly diet salad dressing, or even a vinegar and oil dressing for salad. The resident reported using a regular dressing on the salad negates the purpose of having a salad. Additionally, the resident indicated for over a year the facility had been weighing him once a week and never once did anyone offer any dietary consults to assist him/her with better diet choices. The resident shared that he/she had gained over one hundred pounds since admission and now his/her blood sugars were through the roof and so now everyone is concerned. "Why didn't someone help me 6 months or more ago?" The resident reported that he/she would like to have more choices of foods with less carbohydrates, but that was not the choices he/she received on the meal order tickets.

Regarding depression/counselling:
Review of nursing notes included on 3/4/19 at 7:28 PM, an increase in Duloxetine HCL DR (delayed release), 30 mg (milligrams), give 90 mg, daily for depression/MDD.

On 4/9/19 at 9:48 AM, the resident continued that between 1-2 months ago he/she requested counselling, indicating in the past a history of depression. The resident indicated that he/she

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voiced this to the physician and the facility staff and now going on 2 months continued to await an appointment.

Regarding pain concerns:
On 3/22/19 at 3:57 PM, the resident's sister visited and a discussion regarding resident's pain control was held.
On 3/26/19 at 4:02 PM, the resident discussed pain issues with PA (physician assistant). Received orders to taper Gabapentin and re-start Lyrica.
On 4/8/19 at 1:00 PM, received an order from the PCP (primary care physician) to increase Lyrica.
On 4/9/19 at 9:48 AM, the resident voiced concerns about his/her pain medications, reporting that a couple of months ago the PCP decided that the resident should not be on Lyrica and Gabapentin. The resident reported he/she had not had any ill-effects and usually had fairly good pain control with the use of these 2 medications, in addition to his/her other pain medication. Since discontinuing the use of the Gabapentin, the resident reported his/her leg pain increased significantly and spent more time in bed because sitting up in the wheelchair was very uncomfortable. The resident further reported that sitting on the current shower chair was extremely painful to a current boil on his/her hip and was unable to stand for the shower due to the leg pain.

On 4/10/19 at 11:15 AM, licensed nursing staff B verified the residents care plans are being reviewed and revised during the care plan meetings, however, the staff are aware that many of the care plans needed a major review and overhaul. The staff noted the facility lacked any short-term care plans for staff use and that all

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changes are made directly to the care plan.

Review of the facility care plan policy dated 7/23/09 included the facility developed an individualized care plan to provide the greatest benefit to the resident including the resident's goals and choices, interventions for preventing avoidable declines in functioning or functional levels, with resident specific interventions.

The facility failed to develop an individualized care plan with appropriate interventions instructing staff in the care needs of the resident regarding dietary needs, pain management and psychosocial

- Resident #49's admission MDS (minimum data set), dated 6/4/18, included a BIMS (brief interview of mental status) score of 15, indicating intact cognition, and the resident expressed feeling down/depressed, trouble with sleep, felt tired, bad about self, and lacked other mood or behavioral concerns. The assessment further identified the resident required extensive assistance of staff for most ADLs (activities of daily living) and used a wheelchair for mobility. The assessment identified the resident received scheduled and PRN pain medications and non-pharmacological interventions for pain. The resident's assessment lacked identification of any dietary concerns.

The quarterly MDS, dated 3/26/19, included a BIMS of 15, felt down/tired, had little interest in doing things, felt bad about self, lacked any rejection of care or other behaviors and required extensive to total dependence for ADLs except eating was independent. The assessment lacked

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identification of eating/chewing/swallowing concerns and lacked identification of a therapeutic diet or weight loss or gain. The pain assessment identified the resident received routine and PRN (as needed) pain medications however, lacked completion of the resident's pain assessment.

The resident's care plan, dated 1/9/19, lacked evidence of allergy notifications; pain management and dietary needs.

Review of the physician orders included allergies to Zofran and Penicillin, however the facility failed to identify this in the care plan.

On 4/9/18 at 8:54 AM the resident voiced concern regarding receiving a medication which he/she was allergic to.

Regarding Pain management:
The resident's care plan, dated 1/9/19, lacked evidence of pain management interventions.

Observation and interview with the resident on 4/9/19 at 11:30 AM, identified the resident seated in a wheelchair, with legs elevated on footrests. The resident participated in exercise activity then sat at a table and worked on a craft project while awaiting lunch to start. The resident also reported the facility seemed to have a problem with keeping his/her pain medication in stock, as several times the facility had depleted their supply before receiving the next order.

On 4/9/19 at 3:50 PM, observation identified direct care staff N and T assisted the resident with transferring into the bed from the wheelchair, utilizing a mechanical lift. The resident provided

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specific instructions to the staff during the transfer.

On 4/10/19 at 10:46 AM, direct care staff U and V provided arising cares to the resident, using the mechanical lift to transfer the resident and providing full care. The resident voiced to the staff a level of discomfort until the resident was positioned in a certain manner in the chair, then expressed satisfaction to the staff.

Interview, on 4/10/19 at 11:01 AM, direct care staff V reported the resident required total care, except ate independently; the staff reported the resident became upset easily about things not within his/her control and tended to take things very personally, and at times was emotional. Required extra time to work with, but when taking time and doing the job to his/her satisfaction, usually have a good outcome.

Interview, on 4/15/19 at 1:10 PM with administrative nursing staff C reported the residents pain medication required a physician order and insurance approval which sometimes caused a delay.

Dietary needs:
Review of the physician orders included an order for a regular diet, ordered 12/4/18.

Interview, on 4/9/19 at 8:54 AM, with the resident identified several concerns regarding the resident's care and treatment. The resident voiced concerns with the delivery of meals from the dining room and indicated that several times the resident's meal delivery was very late; reporting that last night the staff failed to deliver dinner and at 8:30 PM when he/she realized the

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time, the kitchen staff had left, and the nursing staff had to find something in the kitchen for him/her.

On 4/10/19 at 11:15 AM, licensed nursing staff B verified the residents care plans are being reviewed and revised during the care plan meetings, however, the staff are aware that many of the care plans needed a major review and overhaul. The staff noted the facility lacked any short-term care plans for staff use and that all changes are made directly to the care plan.

Review of the facility care plan policy dated 7/23/09 included the facility developed an individualized care plan to provide the greatest benefit to the resident including the resident's goals and choices, interventions for preventing avoidable declines in functioning or functional levels, with resident specific interventions.

The facility failed to develop an individualized care plan with appropriate interventions instructing staff in the care needs of the resident regarding dietary needs, pain management and allergy notifications.

- Resident #35's admission MDS (minimum data set), dated 3/26/19, indicated long and short-term memory impairment with varied levels of consciousness and lacked evidence of any behaviors. The assessment identified the resident required extensive assistance of staff for ADLs (activities of daily living) with supervision needed for eating and total dependent for bathing, no ROM impairment and used a wheelchair for mobility. The assessment identified the resident required a mechanically altered diet and lacked evidence of oxygen use.

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The CAAs, dated 3/29/19 lacked clarification regarding oxygen use as the MDS lacked identification of the use of oxygen.

The resident's care plan, dated 3/26/19, lacked evidence of individualized interventions for the resident's oxygen use.

Review of physician orders included the use of 02 (oxygen) via nasal cannula at 2 liters to maintain an 02 saturation of 90% or above. Ordered 3/22/19.

On 4/3/19 at 9:38 AM, documentation identified the resident assessed by the nursing staff and noted resident's lung sounds clear with unlabored respirations.
On 4/4/19 at 2:09 AM, nursing notes documented the resident transferred to the hospital for further treatment per family request. The nursing documentation lacked evidence of the use of oxygen to maintain oxygen saturations as ordered.

Review of hospital admission records dated 4/4/2019 evidenced the resident exhibited an oxygen saturation of 73% at the time of the EMS (emergency medical services) arrival at the facility.

On 4/10/19 at 11:15 AM, licensed nursing staff B verified the residents care plans are being reviewed and revised during the care plan meetings, however, the staff are aware that many of the care plans needed a major review and overhaul. The staff noted the facility lacked any short-term care plans for staff use and that all changes are made directly to the care plan.

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F 656	Continued From page 37 Review of the facility care plan policy, dated 7/23/09, included the facility developed an individualized care plan to provide the greatest benefit to the resident including the resident's goals and choices, interventions for preventing avoidable declines in functioning or functional levels, with resident specific interventions. The facility failed to develop an individualized care plan with appropriate interventions instructing staff in the care needs of the resident regarding use of oxygen.	F 656		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility reported a census of 89 residents with 28 selected for sample review. Based on observation, interview, and record review, the facility failed to ensure adequate social services for one resident (#29) of the facility, when the facility failed to ensure the resident received the services requested for grief counselling, in a timely manner. Findings included: - Resident #29's diagnoses from the Physician's Order Sheet, dated 3/28/19, included a diagnosis of MDD (major depressive disorder - category of mental health problems displaying feelings of sadness, helplessness, guilt, wanting to die were	F 745		

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more intense and persistent than what may normally be felt from time to time).

An annual MDS (minimum data set), dated 11/30/18, evidenced the resident with a BIMS (brief interview of mental status) score of 15, which indicated the resident's cognition remained intact. Additionally, the assessment lacked any evidence of mood or behavioral concerns. The resident required extensive assistance for most ADLs (activities of daily living).

The quarterly MDS, dated 3/2/19, lacked changes in cognition, mood and behaviors, however indicated improvement in ADLs to supervised or independent.

The psychotropic drug CAA (care area assessment), dated 12/4/18, included the resident being alert and able to verbalize needs/concerns, but at risk for depression secondary to nursing facility placement. Behaviors are monitored every shift by the licensed nurse and the resident is followed by the PCP (primary care physician).

The resident's care plan dated 12/26/18 lacked any instruction regarding social service needs.

Review of the physician orders, dated 3/4/19, identified the PCP (primary care physician) increased the resident's Duloxetine HCL DR (delayed release), 30 mg (milligrams) capsules, give 90 mg, by mouth daily for depression. This order was increased from 60 mg daily.

Review of the nursing notes, from 3/1/19 to current identified the following information:
On 3/16/19 at 10:52 AM discussed with the

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resident ways to enable the resident to get out [of room] and go to activities. The resident requested to change the time of Lasix to evening, nurse informed the change in time would keep him/her awake at night urinating. The resident indicated that he/she is awake most of the night anyway and would rather not have to rush to the bathroom during the day while trying to enjoy activities. The writer changed the time of Lasix to evening.

On 3/17/19 at 11:15 AM the resident was out of his/her room for breakfast this morning and appeared to be in a good mood. Singing gospel songs with other residents and lacked any complaint of pain.

On 4/9/19 at 9:48 AM, an interview with the resident identified several concerns, including weight concerns, health concerns, and concerns regarding staff treatment of the resident. The resident appeared very down and explained that he/she had lived at the facility well over a year and just felt as though the staff no longer cared about the resident's welfare. The resident indicated the staff often talk down to the resident and reported that even the doctor did not seem to care when the resident expressed having increased pain, having increased depression and isolating him/her self and nothing was being done. The resident further explained that he/she had a history of depression. His/her spouse died a few years ago and sometimes it just was overwhelming to him/her that the spouse was gone and now all he/she had was this room and these few things. Additionally, the resident reported that his/her adult children were both leaving the United States on missionary trips and was dealing with that as well. The resident

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reported he/she had always been a social person and loved to lead ministry and song in the facility, however, no longer participated much in any of this. The resident noted that a few weeks ago, he/she had requested to have counselling set up for him/her self and had yet to hear anything about an appointment. The resident reported he/she had spoken with the facility about these issues and nothing was being done. The resident noted that the staff could be kinder, it appears they just don't want to be bothered; he/she always heard that it takes less effort to smile than to frown. Additionally, the resident reported being unaware of any recent medication changes. The clinical record lacked evidence of the resident being informed of the increase in his/her anti-depressant.

Observation throughout the day identified the residents room door remained shut, unless a staff member entered the room. The resident remained in the room during observations throughout the day.

On 4/9/19 at 1:27 PM, the resident rested on the bed, however, sat onto the edge of the bed upon knocking on the door. The resident seemed pleased to have a visitor and talked until lunch arrived at 1:30 PM.

On 4/10/19 at 8:30 AM the resident sat on the edge of the bed, eating breakfast. The resident again seemed pleased to have a visitor and wanted to chat.

On 4/10/19 at 9:05 AM, direct care staff CC reported the resident was mostly independent in his/her cares, although needed assistance with emptying the basin used as a urinal. The staff

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reported he/she usually called whenever he/she needed anything, and that when working the staff member would check on all the residents on his/her hall at least every 2 hours. The staff noted the resident had for a few weeks been refusing to get out of his/her room much and had been refusing showers some. The resident used to eat some in the dining room and come out for some activities, but not for a few weeks now.

On 4/10/19 at 10:22 AM, administrative nursing staff C reported the resident had been unhappy frequently about medication, foods, etc.

On 4/14/19 at 2:30 PM, observation identified the resident out to the dining room for the afternoon musical program. The resident appeared to smile and enjoy the fellowship with other residents.

On 4/15/19 at 2:10 PM, the resident reported he/she had not heard anything about counselling. The resident made the facility and the PCP aware on 3/4/19 of the need for counselling and 43 days later the resident awaited the requested assistance.

Interview with administrative staff A on 4/16/19 at 2:30 PM identified that the facility staff were working on establishing a counselling service for the resident. The staff verified recently hired a licensed social worker for the facility, following the former employee leaving employment, without any notice and the new staff member was learning the needs of the residents.

The facility failed to ensure this resident received timely and appropriate social services to maintain as the highest level of physical, mental and psycho-social well-being possible, when the

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F 745	Continued From page 42 facility failed to assist the resident timely in a request for counselling related to the resident's spouse's death and other personal matters. The resident requested counselling on 3/4/19 and 43 days later still had no information on the requested appointment.	F 745		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility reported a census of 89 residents with 3 residents reviewed for accuracy of medication administration. Based on interview and record review, the facility failed to ensure the staff provided only physician ordered medications to the 2 of 3 residents reviewed, including residents # 29 and 49. Findings included: - Resident # 29's annual MDS (minimum data set), dated 11/30/18, evidenced the resident with a BIMS (brief interview for mental status) identified a score of 15, indicating the resident with intact cognition. The assessment evidenced the resident required extensive assistance for most ADL's (activities of daily living). A quarterly MDS, dated 3/2/19, lacked changes in BIMS status, however, identified the resident required supervision and/or was independent with ADLs. A care plan, dated 12/26/18, instructed staff in	F 760		

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providing medications to the resident, as ordered by the physician.

Review of nursing notes, documented on 1/23/19 at 11:47 AM, identified an "Alert Note" regarding the resident receiving: 1) Metoprolol, 50 mg (milligrams), 2) Losartan 100 mg, 3) Amlodipine, 5 mg, and 4) Cephalexin, 500 mg. The PCP (primary care physician) received notification at the time of the medication error. The residents BP (blood pressure) was 153/81 and pulse was 83. Will continue to monitor BP hourly x 4 hours, every 2 hours x 2, and every 4-hour x 4. The Metoprolol, Losartan and Amlodipine are all used to treat hypertension; cephalexin is an antibiotic. These four medications were not ordered for this resident.

Review of the incident investigation included: the nurse was in a hurry and made a mistake. The staff statement included: Licensed nursing staff M reported he had 2 resident's medications in medication cups on the medication cart. The staff grabbed one cup, which the staff noted the letter "G" on and administered the medications to resident #29. A few minutes later the staff went to administer resident #87's medications and realized that the cup with the letter "D" should have been delivered to resident #29. The staff reported being in a hurry and further noted, that typically the staff member does not pre-setup medications, and did not recall why he/she did so in this situation. Staff M further reported that he/she monitored the resident's BP the remainder of his/her shift and gave report to continue monitoring the BP per the physician's orders.

Review of the resident's blood pressure readings on 1/23/19 included:

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F 760	Continued From page 44 9:30 AM -- 144/76 10:30 AM -- 130/65 11:30 AM -- 120/60 The staff only monitored 3 hours, not the ordered 4 times. 1:23 PM -- 153/81 The staff only monitored one time of the every 2 hours x 2 ordered. 1:28 PM -- 105/63 4:36 PM -- 110/63 The staff monitored the residents BP 1 time at 3 hours and then failed to monitor any of the every 4 hours x 4 as ordered. The facility failed to monitor the resident's BP per the PCP orders following the medication error. Observation and interview, on 4/9/19 at 9:48 AM, identified the resident seated on the edge of his/her bed. The resident spoke openly about concerns identified in the investigation. The resident confirmed the occurrence of medications received in error a couple of months ago. The resident reported the staff quickly realized the error and came running back into the resident's room to stop the resident from taking the medication, however, the resident had already taken the medications. The resident reported having no ill effects, other than being a bit tired for the day. The resident verified that several times that day, the nurse came in and monitored the resident's blood pressure. On 4/10/19 at 10:22 AM, administrative nursing staff C reported that this resident was frequently unhappy about his medications. The facility recently provided additional training and education to the nursing staff regarding documentation and refusals, of medications. At a later date, the staff reported that at the time of the	F 760		

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medication error, the staff did receive education regarding the 5 rights of medication administration, however, no documentation to this effect could be found.

On 4/18/19 at 3:00 PM, licensed nursing staff M reported the medication error was a fluke, and the staff member did not routinely pre-setup resident's medications. Staff M further reported that upon realizing the error he/she immediately called the PCP and received an order to monitor the resident hourly for 4 hours, then every 2 hours times 2 and then every 4 hours times 4. The nurse indicated that he/she failed to implement a physician's order for the monitoring of the resident's blood pressure related to the medication error, however, recalled that he/she reported to the on-coming shift regarding the medication error and need for follow-up of blood pressure monitoring. The staff verified the lack of follow-up of the resident's blood pressure monitoring, per the physician's orders related to a medication error; or any other follow-up documentation/assessment of the resident in the resident's clinical record.

The facility policy, dated 4/24/19, included all medications are administered safely and appropriately per physician order to address the resident's diagnoses and signs and symptoms.

The facility failed to ensure this resident remained free of significant medication errors when the resident was administered another resident's medications related to staff failure to administer medications in accordance to acceptable standards of practice.

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- Resident # 49's ECR (electronic clinical record) identified the resident allergic to the medication Zofran.

An admission MDS (minimum data set), dated 6/4/18, included a BIMS (brief interview of mental status) score of 15, indicating the resident with intact cognition. The assessment further identified the resident required extensive assistance of staff for most ADLs (activities of daily living) and used a wheelchair for mobility.

The resident's care plan dated 1/9/19, lacked evidence of interventions to prevent the resident from receiving medications with known allergic reactions.

A hospital H&P (history and physical), dated 11/15/18, evidenced an allergy to Zofran and identified hallucinations a reaction to the use of Zofran.

A physician order, dated 10/1/18 ordered Zofran, 4 mg, every 6 hours, PRN (as needed), ordered on 10/1/18.

The residents ECR and paper chart review identified the consultant pharmacist in December of 2018, recommended to discontinue an order for Zofran for nausea, related to allergic to the medication, which the PCP approved, and staff noted on 12/14/18.

Review of the physician order summary, dated 3/28/19, identified Zofran as an allergy, as did the February, March, and April MAR's (medication administration records). Additionally, review of the February, March and April 2019 MARs lacked evidence of orders for Zofran administration.

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On 2/19/19 at 1:29 PM, the documentation evidenced the resident complained of SOB (shortness of breath), weakness, poor appetite and other respiratory complaints. The facility notified the PCP of the symptoms and the physician ordered a chest x-ray and flu swab.

On 2/20/19 at 3:48 AM, the nurse documented checking on the resident around 10:30 PM and the resident expressed not feeling well. The nurse conducted an assessment and identified a temperature of 101.3 degrees Fahrenheit with productive cough and greenish sputum. The resident additionally complained of being SOB and with a headache. Staff provided Tylenol, PRN (as needed) and a PRN breathing treatment; notified the physician of the resident's complaints and effectiveness of the Tylenol (98.6 degrees Fahrenheit.)

The clinical record lacked any documentation related to the resident receiving the Zofran or any follow-up of the facility monitoring the resident following the knowledge of the resident receiving the medication, which the resident was known to have allergies to.

The facility provided an internal investigation into an allegation of a medication error, however, this was not documented or noted as a follow-up assessment for the resident in the ECR. The investigation, dated 2/26/19, consisted of a brief typed memo noting the resident received a dose of Zofran, on 2/26/19, although the residents ECR documented an allergy to the medication. Administrative staff A documented the investigation determined that a CMA (certified medication aide) administered the medication

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even though the E-MAR (electronic medication administration record) lacked an order for the medication. CMA S reported when the resident requested something from the aide for nausea, the staff member located a card of Zofran in the medication cart and administered the medication according to the label. The facility placed the CMA on suspension pending results of the investigation. The facility notified the PCP who indicated the resident would not have suffered any negative outcome because of the medication administration error. Additionally, the facility removed the discontinued medication card from the medication cart. The investigation failed to identify the lack of adequate assessment by the nursing staff following notification of a medication error.

Observation, on 4/9/19 at 11:30 AM, identified the resident seated in the dining area, participating in exercise activity and then a craft project. The resident appeared comfortable and at ease, while seated with a table mate with whom the resident conversed back and forth.

Interview, on 4/9/19 at 8:54 AM, with the resident identified a concern that the staff provided a medication to which the resident was allergic to and indicated the medication caused the resident to suffer from hallucinations after receiving the medication.

Interview, on 4/10/19 at 2:50 PM, with direct care staff W reported the resident received a requested medication for nausea and was later found the medication had been discontinued because the resident was allergic to the medication. The staff reported not understanding why the medication card remained in the cart

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when the PCP ordered the medication discontinued.

Interview on 4/11/19 at 3:00 PM, with direct care staff S verified the administration of the medication to the resident.

On 4/15/19 at 2:50 PM, licensed nursing staff Q reported when an order was discontinued the order was taken, the E-MAR and the ECR orders are changed and the staff would then pull the medication out of the medication cart. That medication is then locked into storage for review and destruction by the pharmacy consultant. The staff verified the medication should not have been left in the cart and the staff should have documented follow-up charting on the resident in relation to the medication error.

On 4/16/19 at 12:05 PM, administrative nursing staff C reported the resident did have an allergy to Zofran, particularly the resident had a reaction to IV (intravenous) Zofran of hallucinations, per documentation in the clinical record. However, the staff further reported that a single dose of by mouth Zofran was unlikely to have caused the resident to hallucinate, as the resident had reported. In fact, nursing staff C reported, the facility was unaware for several days after the administration of the medication to the resident. When the resident reported it to us, we did investigate and took appropriate action. The nurse verified the lack of assessment with documentation for the resident following the medication error.

On 4/16/19 at 2:10 PM, PCP X reported the half-life of Zofran was around 3-4 hours, so no way could the resident have hallucinated for that

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F 760	Continued From page 50 length of time. The facility policy, dated 4/24/19, included that all medications are administered safely and appropriately per physician orders. The facility failed to ensure the resident remained free of significant medication errors and only received only medications ordered by the physician and failed to ensure medications which the resident had allergies too, when discontinued, were removed from the medication cart.	F 760		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: The facility reported a census of 89 residents with 5 residents sampled for diet review. Based on observation, interview, and record review the facility failed to ensure 3 of 5 resident's, including resident #29, 40 and 87, reviewed received diets per the physician's orders. Findings included: - Resident # 29's annual MDS (minimum data set), dated 11/30/18, evidenced the resident with a BIMS of 15, indicating intact cognition and	F 808		

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without any mood or behavioral concerns. The resident needed extensive assistance for most ADLs (activities of daily living and identified a lack of dietary concerns, and with a therapeutic diet.

A quarterly MDS, dated 3/2/19, lacked changes in the BIMS and mood/behavior, however indicated improvement in ADLs to supervised and independent and without changes to the dietary assessment.

The ADL CAA (care area assessment), dated 12/5/18, included the resident as alert and verbalized needs/concerns. Res required some assistance with ADLs and transfers.

The nutritional CAA, dated 12/4/18, included the resident consumed meals independently with a good appetite. Staff weighs the resident routinely. The resident triggered for potential weight loss secondary to diuretic use.

A nutritional assessment, dated 1/3/18, identified a diet order of regular diet with diet condiments.
On 1/19/18 the resident expressed concern regarding increased blood sugars and requested menus with limited concentrated carbohydrates.
A recommendation of changing to a CCHO diet was made.
On 6/2/18 the staff documented the resident on a CCHO (concentrated carbohydrate-controlled diet) with diet condiments.
On 6/18/18 a follow-up diet order and communication noted to include an allergy to seafood and peanuts.
On 12/20/18 a quarterly nutrition assessment identified the resident stayed in his/her room for meals, was able to feed self, and often ordered double portions. The resident's skin remained

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intact with a CCHO diet with diet condiments of regular texture. The resident made own choices of food intake and talked about making improved diet choices to reduce caloric intake, however, does not follow through when ordering meals, choosing to have extra portions.

The resident's care plan, dated 12/26/18, lacked instructions to the staff on the resident's desired and physician ordered dietary needs.

Review of the resident's physician orders included a diet order of CCHO (concentrated carbohydrate controlled) diet with regular texture, thin consistency liquids and diet condiments. Ordered 12/18/18.

On 4/9/19 at 9:48 AM, the resident sat on the edge of the bed, beginning breakfast. Per review of the resident's dietary order, the resident ordered 2 bowls of cheerios, 2 cartons of milk, 2 sausage patties and 4 slices of bacon, yogurt and chocolate milk. The kitchen sent: bacon, sausage, 1 whole milk, 1 2% milk, and 2 bowls of frosted flakes (resident reported yesterday he got fruit loops when he had ordered cheerios -- Been out of cheerios for several days.)

On 4/9/19 at 1:30 PM, the staff delivered the resident's lunch tray to the resident's room. The resident reported, the kitchen filled the order properly including corned beef, potatoes with cabbage, cauliflower, and grapes.

On 4/10/19 at 8:30 AM the resident sat on the edge of the bed, with a tray in front of the resident. The resident ordered for breakfast, per review of the order slip: pancakes, bacon, sausage, 2% milk, chocolate milk, tomato juice, 1

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF ANDOVER	621 W 21ST, PO BOX 100 ANDOVER, KS 67002

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bowl of cheerios and yogurt. The kitchen sent: 8-10 sausage links, 2 biscuits, 2 bowls of fruit loops, 1 2% milk, 1 chocolate milk, and a yogurt. 9:20 AM, the resident requested pain medication from the CNA.

Interview, on 4/9/19 at 9:48 AM, with the resident reported he/she had several concerns about his/her treatment and care at the facility. The resident reported he/she addressed all these concerns with the staff and the facility was aware of the concerns. The resident reported that for over a year since coming to live at the facility, they had failed to offer diet condiments, particularly diet salad dressing, or even a vinegar and oil dressing for salad. The resident reported using a regular dressing on the salad negates the purpose of having a salad. Additionally, the resident indicated for over a year the facility had been weighing him once a week and never once did anyone offer any dietary consults to assist him/her with better diet choices. The resident reported that he/she would like to have more choices of foods with less carbohydrates, but that was not the choices he/she received on the meal order tickets.

On 4/11/9 at 8:25 AM dietary staff F reported completing ordering for the facilities dietary department and reported the facility had stock on tomato juice and cheerios and had no idea why the staff told the resident they were out of stock. Additionally, staff F reported for diet condiments the facility stocked diet jelly and syrup, but not any diet salad dressing.

The Therapeutic Diet policy, dated 1/9/19, instructed the facility would provide diets as prescribed by the physician to support the

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treatment and plan of care for the residents.

The facility failed to follow the resident's physician ordered diet of CCHO with provision of diet condiments when the staff provided high in sugar cereals of fruit loops and sugar frosted flakes. Additionally, the staff failed to offer limited carbohydrate choices to the resident for healthier diet choices and failed to stock diet condiments, such as diet salad dressing for the residents.

- Resident #87 annual MDS, dated 5/4/18 included a BIMS (brief interview of mental status) score of 15 indicating intact cognition. The assessment lacked identification of any mood or behavioral concerns as well as no chewing or swallowing concerns. The assessment reflected the resident required supervision for eating.

A quarterly MDS, dated 1/17/19, lacked completion of the cognition and identified a change to independent with eating, otherwise no changes were identified.

A diet order in the clinical record, dated 12/4/18, evidenced a regular diet, regular texture with thin consistency fluids. The diet order further identified the resident preferred vegetarian diet, related to textures, however, does eat bacon and hamburger.

An intervention in the resident's care plan, dated 4/1/19 included the resident preferred vegetarian foods. Allow the resident to order foods preferred while encouraging healthy choices.

A progress note, in the clinical record, evidenced on 9/7/18, the RD (registered dietician) was

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working with the dietary manager to provide a written menu of vegetarian options for this resident to improve his satisfaction with meals. An interview with the resident today about additional ideas, included the resident did not like "veggie burgers" or the "fake chicken nuggets." The resident had enjoyed cheese manicotti and ravioli, egg salad and burritos. Told him of our plan and goal to have a menu to provide within the coming week.

A RD evaluation, dated 1/31/19, identified the resident ate in the main dining room, with the ability to eat independently as well as making own menu selections. The RD and dietary manager developed written menus for the resident, of his preferences.

The staff failed to provide these menus when requested, during the survey process.

Observation, on 4/9/19 at 1:15 PM, identified the resident served an egg salad sandwich with chips for lunch, one hour following the meal service beginning. The resident was in the dining room at 12:30 PM when the meal service began. Other options included tomato soup and crackers, vegetable of the day, and dessert.

Observation on 4/10/19 at 4:20 PM, identified the RD visiting with the resident concerning likes and dislikes.

At 6:00 PM on 4/10/19 the resident sat in the dining room. The resident was served a bowl of chili beans with grated cheese. The resident's order slip indicated the resident was offered and ordered a baked potato with cheese and sour cream, along with dessert of the day. The

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resident indicated the staff notified him/her at meal time the baked potatoes were not available

On 4/11/19 at 1:15 PM, observation of the residents dining table identified a partially eaten cold cheese sandwich with tomatoes, a partially eaten bowl of coleslaw, and an untouched dinner roll without any butter. The resident had left the table. In the hallway, the resident was upset, indicating he/she was very tired of sandwiches. The resident indicated the kitchen was out of sherbet and serving ice cream, which he/she also did not eat.

Interview, on 4/9/19, at 9:38 AM, with the resident identified a concern with the availability of vegetarian foods, per his/her request. The resident indicated being tired of receiving a bowl of chili beans, or refried beans (without any salsa or cheese or anything else). The resident reported his/her adult sibling spoke to the facility about the matter and was told, if they didn't like it they could move. Additionally, the resident reported the other night he/she had hash browns and a piece of cheesecake for supper.

On 4/10/19 at 8:50 AM, the resident reported that last evenings meal was terrible, and that staff lost the meal ticket. He ended up with some sliced tomatoes and grapes for supper.

The facility failed to ensure the development of a vegetarian diet for the resident who expressed the desire to not eat most meats, and failed to follow the physicians orders.

- Resident #80's admission MDS, dated 9/16/18

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included a BIMS of 13, indicating intact cognition and lacked identification of any swallowing or dental issues. Required supervision for eating.

The resident POS (physician order summary), undated for 3/27/19 identified an order for a regular diet with mechanical soft texture, thin consistency fluids. House shakes daily.

On 4/9/19 at 12:50 PM the resident received a meal of baked breaded fish, corn O'Brien with bacon crumbles and a dinner roll. The resident's menu slip called for ground baked fish, creamed corn, parmesan cauliflower and dinner roll. The resident attempted to eat the fish and stated it was too crispy and pushed the fish aside. A dietary staff member came to the table and verified the fish should be ground and got the resident a dish of ground fish, which the resident consumed 100% of.

On 4-10-19 at 7:57 AM the staff provided the resident a bowl of oatmeal and a strawberry health shake which he/she poured on the oatmeal. The resident stated liking the oatmeal that way, no straw or glass was given to the resident for his/her health shake.

On 4/11/19 at 12:55 PM the staff provided the resident a meal of noodles with beef tips. The resident reported being unable to eat the beef tips and needed them ground up. The staff further failed to provide a cup or straw for drinking the carton of health shake provided with the meal.

The facility policy for Therapeutic Diets, dated 1/9/19, included to follow the physician's orders for the diets while meeting the resident's goals and preferences. A modified texture diet is

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F 808	Continued From page 58 specifically prepared to alter the consistency of food to facilitate oral intake of food. The facility failed to provide the resident with a mechanically soft diet, as ordered.	F 808		