STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175441	A. BUILDING _____ B. WING _____	C 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE SHALOM INC	5500 WEST 123RD ST OVERLAND PARK, KS 66209

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00181449. The 2567 was sent electronically on 08/17/23.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: The facility identified a census of 65 residents. The sample included four residents. Based on record review, interview, and observation, the facility failed to ensure Resident (R)1's diuretic (medication to promote the formation and excretion of urine) was administered, weights monitored, and medication change clarified. This placed the residnet at risk for complications related to heart failure and fluid overload. Findings included: - R1's Electronic Medical Record (EMR) documented under the "Diagnosis" tab included the following diagnoses: acute/chronic diastolic (congestive) heart failure (CHF-a condition in which your heart's main pumping chamber (left ventricle) becomes stiff and unable to fill	F 684		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/17/2023

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properly), atrial fibrillation (A-fib - rapid, irregular heart beat), lymphedema (swelling caused by accumulation of lymph), and localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "Admission Minimum Data Set" (MDS) dated 06/13/23 documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. R1 had total dependence of two staff members for transfers. R1 required extensive assistance of two staff members for bed mobility and toilet use. R1 required extensive assist of one staff member for personal hygiene, dressing, and locomotion on the unit. R1 had total dependence of one staff member for locomotion off the unit. R1 received diuretics during the seven day look back period.

The "Urinary Care Area Assessment" (CAA) dated 06/13/23 documented R1 received daily diuretic medications which may contribute to incontinence.

The "Care Plan for Cardiovascular Disease" dated 06/14/23 documented directed staff to monitor for signs and symptoms of cardiovascular complications which included shortness of breath, chest pain, edema, dizziness, nausea, dysrhythmia (irregular heart rhythm), or heartburn. It further directed to monitor vital signs as ordered and as needed and report abnormalities to physician.

The "Care Plan for the Potential of Fluid Overload" dated 06/13/23 directed staff to monitor weight as otherwise ordered.

The "Physician Orders" located in the EMR noted

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the following physician's orders related to edema: 06/06/23 obtain daily weight before breakfast and notify the physician with weight gain of more than two pounds (lbs) in one day or five lbs in one week.

06/06/23 give furosemide (diuretic medication) 40 milligrams (mg) tablet-take one tablet by mouth two times per day for CHF. Medication discontinued on 06/20/23.

06/20/23: furosemide 40 mg tablet-take one tablet by mouth two times a day for CHF. Medication was discontinued on 07/07/23.

07/07/23 Torsemide (diuretic) 20 mg tablet by mouth twice a day. Medication was discontinued on 07/07/23.

07/07/23 Torsemide 20 mg tablet-40 mg by mouth once daily. Medication was discontinued on 07/13/23.

07/11/23 Torsemide 20 mg by mouth one time order for edema. Medication was discontinued on 07/11/23.

07/11/23 Torsemide 20 mg - 40 mg by mouth one time order for edema. Medication was discontinued on 07/12/23.

07/13/23 Torsemide 20 mg - 40 mg by mouth once daily. Medication was discontinued on 07/20/23.

R1's July 2023 "Medication Administration Record" (MAR) documented R1 received furosemide 40 mg twice a day 14 out of 14 opportunities July 1st through July 7th. R1

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received Torsemide two out of six scheduled opportunities July 7th through July 12th, and one time as ordered for one time dose at PM on July 11th.

R1's July 2023 "Treatment Administration Record" (TAR) documented R1 was weighed 10 out of 12 chances at the beginning of July 1st through July 12th, but lacked an actual weight being documented on the TAR.

Review of the "Vitals" tab revealed the following weights:
07/03/23 312.2 lbs
07/07/23 319.0 lbs
07/08/23 320.6 lbs
07/11/23 316.0 lbs

The "Nurses Practitioner Note" dated 07/07/23 at 08:18 PM documented R1 had a weight gain since admission. R1 was furosemide 40 mg twice and day, which was changed to Torsemide 20 mg twice a day.

The "Addendum Progress Note" dated 07/10/23 at 03:11 PM documented a correction 20 mg of Torsemide was changed to Torsemide 40 mg faxed to pharmacy.

The "Addendum/Correction Note" dated 07/11/23 at 02:50 PM documented Consultant GG updated the order to administer 40 mg that evening to total 60 mg Torsemide. Original order dated 07/11/23 at 02:50 PM documented new order from Consultant GG via phone for 20 mg Torsemide that evening due to increased shortness of breath (SOB).

The "Nurse Practitioner Note" dated 07/12/23 at

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10:19 AM documented R1's furosemides 40 mg twice a day was changed to Torsemide 20 mg twice a day. That Torsemide order was changed in the EMR to 40 mg every day and a new script was sent to the pharmacy. Despite the medication order and the script being correct to 40 mg every day, an unidentified nursing staff was confused on which dosage to use. Consultant GG noted that the on-call provider was not contacted for clarification related to this issue. Consultant GG was contacted by an unidentified Licensed Nurse (LN) and received report R1 had increased shortness of air (SOA) but was stable. R1 reportedly received 20 mg Torsemide that AM. Consultant GG ordered a one time does of 40 mg Torsemide given, and staff to follow R1 closely. R1 was seen that AM with concerns from LN G regarding R1's current status. R1 was lethargic and difficult to arouse, lung sounds were coarse with auscultation. R1 reported feeling sort of breath that AM. 911 was called and R1 was transported to the emergency room. LN G stated R1 was admitted to the hospital for CHF exacerbation (increase in or worsening of heart failure symptoms).

On 08/03/23 at 02:00 PM LN G stated that an order that had concerns or needed to be clarified would appear pink on the screen. LN G further stated that indicated the order needed to be addressed to find out why the order had not been activated. LN G revealed that if she had a question related to a residents medication order, she called to clarify the order. LN G further revealed that if a resident had ordered daily weights and those weights were missed or different from the day before she would contact the physician for directions on how to handle this concern.

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On 08/03/23 at 02:09 PM R1 sat in her wheelchair parallel to her bed watching television. R1 was well groomed and in good spirits. R1 revealed that when she left the facility and was sent to the ER, R1 revealed that she had fluid removed from her body while in the hospital, but she felt much better now.

On 08/03/23 at 04:21 PM Administrative Nurse D stated that the Torsemide medication order was entered by Consultant GG, and it failed to show up with a time code. Administrative Nurse D revealed that if an order was entered and failed to have a time code. She further said she expected the nurses to notify the physician if an order clarification was needed or when a resident's daily weight was up per ordered parameters.

On 08/03/23 at 04:21 PM Administrative Nurse E stated that the charge nurse that worked the evening did not see the order that Consultant GG entered. Administrative Nurse E stated it was not exactly known how orders entered in triggered for the staff to see. Administrative Nurse E revealed that with the weight order placed in the TAR, the staff sign off on noting it was completed, but there was no entry for the weights to be recroded for monitoring. Administrative Nurse E further revealed that the staff would ahve to go to the "Vitals" tab to enter the weight that was obtained.

On 08/03/23 at 04:32 PM Consultant GG stated she expected the nurses to clarify the orders if they had questions. Consultant GG further stated she expected the nurses to get the daily weights if it was ordered for a resident.

The facility's policy "Administering Medications &

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F 684	Continued From page 6 Medication Administration" revised 01/22/23 documented if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the nurse shall contact the resident's attending physician or the facility's medical director to discuss the concerns. The facility failed to ensure R1's diuretic was administered, weights monitored, and medication changes clarified. This placed the residnet at risk for complications related to heart failure and fluid overload.	F 684		