

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2016
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
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F 000	INITIAL COMMENTS	F 000			
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. Based on observation, interview and record review the facility failed to provide a clean, orderly, and comfortable interior in 3 of 3 neighborhoods for 3 of 4 days.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Maintenance Logs dated 11/22/15 to 3/18/16 documented complaints of resident rooms, bathrooms, care equipment, and numerous resident complaints of odors when the biohazard and soiled utility doors were open. The record lacked a documented resolution for complaints of odors. <p>During observations on 3/15/16 between 9:02 A.M. and 11:31 A.M., the soiled utility room located in neighborhood 2, overflowed with soiled linen and trash barrels, propped open lids and emitted a foul odor. The biohazard room located in neighborhood 3 had no biohazard waste, but emitted a foul odor when the door was opened. The rooms lacked negative pressure ventilation in</p>	F 253			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 253	<p>Continued From page 1</p> <p>both soiled and biohazard rooms and the soiled utility room was accessible to all residents. The soiled utility room and biohazard rooms were located next to resident rooms in each neighborhood.</p> <p>During an observation on 3/15/16 at 2:52 P.M. the soiled utility room revealed propped open lids, overflowing bagged linen and trash in barrels. When the door to this room was opened a foul odor was emitted.</p> <p>During an observation on 3/15/16 between 3:02 P.M. and 4:08 P.M. resident rooms and bathrooms were found to be unclean with stained carpet and floors, holes in the walls and doors, and marred and scuffed molding.</p> <p>During observations on 3/16/16 from 7:18 A.M. to 9:52 A.M. the soiled utility room had propped open lids on overflowing soiled linen and trash, which could not be secured closed. A foul odor emitted when both soiled utility and biohazard doors opened.</p> <p>During an observation on 3/16/16 between 1:26 P.M. and 2:02 P.M. resident rooms and bathrooms were found to be unclean with stained carpet and floors, holes in the walls and doors, and marred and scuffed molding.</p> <p>During an observation on 3/21/16 at 9:15 A.M. the biohazard and soiled utility room both emitted foul odors when the doors opened. In the soiled utility room both linen and trash barrels were overflowing above the barrels and lids were propped open.</p> <p>During an observation on 3/21/16 between 2:36</p>	F 253			

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F 253	<p>Continued From page 2</p> <p>P.M. and 3:22 P.M. resident rooms remained in disrepair and were unclean.</p> <p>An observation on 3/21/16 at 5:02 P.M. revealed overflowing trash and linen barrels and the linen barrel lid was located on the floor. A foul odor was emitted when the door opened.</p> <p>During an observation on 3/22/16 between 9:02 A.M. and 9:56 A.M. a tour of all resident rooms and bathrooms with maintenance supervisor X and housekeeping supervisor Y revealed clean rooms and bathrooms. The walls, floors, carpets, and molding were in disrepair and unclean.</p> <p>During an observation on 3/22/16 at 9:22 A.M. overflowing trash and linen barrels were in soiled utility room. The lids of both barrels were propped open and the room had a foul odor.</p> <p>During an interview on 3/21/16 at 5:06 P.M. administrative nursing staff D said staff should empty the soiled utility room linen and trash barrels at least twice a shift and he/she was aware of resident complaints whose rooms were next to or across the hall from both of these rooms. He/she said the soiled utility room should have secured access and understood the sanitary implications of resident access to the soiled utility room.</p> <p>During an interview on 3/21/16 at 1:38 P.M. administrative staff A said he/she understood the 2 soiled rooms and soiled laundry area should have negative pressure exhaust to the outside air. He/she said there was a remodeling plan for the facility to begin in 3 weeks and he/she had corporate's approval to install a negative pressure exhaust in all 3 areas. Staff A said residents</p>	F 253			

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F 253	Continued From page 3 whose rooms were in the area of these rooms were bothered by foul odors. During an interview on 3/22/16 at 9:28 A.M. maintenance supervisor X and housekeeping/laundry supervisor Y said that the soiled utility room should be locked, have secured lids over both barrels and linen and trash should be emptied more often or at least twice per shift. Staff X and Y confirmed the rooms lacked ventilation and said both rooms should have ventilation system. During an interview on 3/22/16 at 12:32 P.M. administrative staff E said the soiled utility room should be locked with a coded access. He/she said the soiled trash and linen should be emptied more often and the lids closed. Staff E said residents located in rooms near the soiled utility and biohazard rooms had complained in resident council meetings and documented in maintenance logs. During an interview on 3/22/16 at 1:56 P.M. administrative staff A said the soiled utility room should have secured access and staff were expected to empty soiled linen and trash more often than once per shift. Review of the facility's Preventative Maintenance policy dated 10/12/2015 documented staff performed preventative maintenance. The facility failed to maintain a clean, orderly, and comfortable interior.	F 253			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278			

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F 278	<p>Continued From page 4</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. The sample included 21 residents. Based on interview and record review the facility failed to accurately reflect the status on 2 of 21 resident MDS' (Minimum Data Set) reviewed for accuracy regarding pressure ulcers. (#60, #81)</p> <p>Findings included:</p>	F 278			

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F 278	<p>Continued From page 5</p> <p>- Review of resident #81's signed physician order sheet dated 3/8/16 documented the resident had a repaired left femur fracture (broken leg).</p> <p>Review of the admission MDS (Minimum Data Set) dated 3/15/16 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition and documented two stage 1 pressure ulcers (an area of redness which does not resolve when pressure was relieved).</p> <p>Review of the resident's care plan dated 3/17/16 failed to document pressure ulcers.</p> <p>The admission Skilled Nursing Service Evaluation and Health Assessment dated 3/8/16 documented a midline incision in the right upper arm, surgical incision left hip and scar on his/her heel. The record failed to document pressure ulcers.</p> <p>During an interview on 3/22/16 at 4:02 P.M. licensed staff L said he/she completed the nursing admission assessment and thought he/she documented two stage one pressure ulcers. He/she was unable to recall a location of the pressure ulcers.</p> <p>During an interview on 3/21/16 at 8:22 A.M. administrative nursing staff E said he/she completed resident assessments (MDS) with a combination of information gathered from direct observation, direct care staff, licensed care staff and the medical record.</p> <p>During an interview on 3/21/16 at 5:22 P.M. administrative nursing staff D said he/she was</p>	F 278			

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F 278	<p>Continued From page 6</p> <p>unsure of this resident's admission assessment.</p> <p>During an interview on 3/22/2016 at 1:12 P.M. administrative nursing staff was unsure why there were no updated information in the resident's care plan and the lack of updated skin assessments.</p> <p>The undated Skilled Nursing Standards of Performance Skin Care Management policy documented licensed nursing staff and the director of nursing administration (DNA) completed weekly wound updates and skin checks for all guests/residents and weekly wound rounds were done with the clinical team, led by the DNS, to assess wound progress and determine the response to the current treatment plan.</p> <p>The facility failed to accurately assess this resident's skin condition and documented the presence of stage one pressure ulcers.</p> <p>- Review of resident #60's signed physician order sheet dated 10/6/15 documented the following diagnoses: peripheral arterial insufficiency of the lower extremities (an abnormal condition of the circulation of blood vessels) and cellulitis to the right lower extremity (a skin infection of the local tissues characterized by heat, redness and swelling). The signed physician order sheet dated 10/9/15 documented 2 unhealed wounds in the right foot related to cellulitis and a diagnosis of gangrene (tissue death) of the right 4th and 5th toes.</p> <p>Review of the admission MDS (Minimum Data Set) dated 10/12/15 documented a BIMS (Brief Interview for Mental Status) score of 13, which</p>	F 278			

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F 278	<p>Continued From page 7</p> <p>indicated intact cognition. The resident needed extensive assistance of 2 staff for bed mobility, and transfers; assistance of 1 staff for locomotion on/off the unit, walking in the room, dressing, toileting, and bathing; and set-up assistance for eating. The resident had no pressure ulcers and had 2 venous or arterial ulcers (wounds caused by poor circulation). Staff provided the resident pressure-reducing devices for his/her chair and bed and a turning/repositioning program.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 10/12/15 revealed a self-care deficit related to weakness, dyspnea (shortness of air), poor balance and cognitive deficits.</p> <p>Review of the Pressure Ulcer CAA dated 10/12/15 revealed the resident was at risk for tissue breakdown or injury related to decreased mobility and incontinence. He/she has wounds on his/her lower legs related to arterial stasis and had a history of peripheral vascular disease with a potential for poor healing.</p> <p>Review of the Braden Risk Assessment scores dated 10/12/15, 10/19/15 and 10/26/15 recorded a score of 15, which indicated the resident was at risk for the development of pressure ulcers.</p> <p>Review of the resident's care plan dated 10/6/15 directed staff to provide 2 staff assistance with ADL's to include, bed mobility and transfers and provide 1 staff assistance with locomotion on/off the unit, walking in the room, dressing, toileting and bathing. Staff revised the care plan on 10/12/15 and directed staff to assess and document wound healing, monitor for worsening of symptoms, and treat wounds in the resident's</p>	F 278			

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F 278	<p>Continued From page 8 lower legs as ordered.</p> <p>Review of the resident's wound clinic notes dated 10/9/15 and 10/16/15 documented some of the resident's wounds were stasis ulcers or blisters and one wound on the bottom of the right foot was recorded as a stage 2 shear and pressure related wound. The wound was documented as open on 10/9/15 and remained open per a physician's progress note dated 10/16/15.</p> <p>An admission skin assessment dated 10/15/2015 documented the resident had open blisters on the top and bottom of his/her right foot . The top wound was open and the bottom wound was closed.</p> <p>The resident discharged on 10/29/15 and was not observed or interviewed.</p> <p>During an interview on 3/22/16 at 4:02 P.M. licensed staff L said the resident had a combination of problems and complications from cellulitis and stasis ulcers. He/she did not recall the specifics about the resident's wound care from 10/2015 or his/her assessments.</p> <p>During an interview on 3/21/16 at 5:22 P.M. administrative nursing staff D said the resident's wounds were related to arterial insufficiency and cellulitis and the resident had no pressure ulcers.</p> <p>During an interview on 3/21/16 at 8:22 A.M. administrative nursing staff E said he/she completed resident assessments (MDS) with a combination of information gathered from direct observation, direct care staff, licensed care staff, and the medical record.</p>	F 278			

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F 278	Continued From page 9 During an interview on 3/22/2016 at 1:12 P.M. staff E said the resident did not have pressure ulcers and his/her wounds were specifically related to stasis and cellulitis. Staff E said the wound doctor sometimes labeled wounds as pressure ulcers, but in this case the wounds were not pressure ulcers. During an interview on 3/22/15 at 3:29 P.M. administrative staff E said he/she tried to accurately document assessments and used documentation from direct care staff, licensed staff, record review, and physical therapy. Review of the undated Skilled Nursing Standards of Performance of Skin Care Management policy documented licensed staff assessed the resident's skin every shift during the first 24 hours and documented findings in the Health and Service Evaluation assessment, initiated a treatment plan for identified skin problems, and implement treatments as ordered by the physician. The facility failed to accurately assess this resident's skin condition and failed to reflect the presence of a physician documented pressure ulcer.	F 278			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 31 residents. The sample included 21 residents. Based on observation, interview, and record review, the facility failed to provide the necessary care and services for pain management for 1 of 1 (#82) residents review for pain.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #82's 2015 electronic health record indicated a diagnoses of anxiety (a feeling of worry, nervousness, or unease), back pain, and left knee effusion (excess fluid that accumulates in or around the knee joint). <p>Review of the 5 day Minimum Data Set (MDS) dated 10/25/16 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The resident received scheduled pain medication, PRN (as needed) pain medication, and non-medication intervention for pain management. The resident identified his/her pain occurred frequently at a scale of 9 (0 was no pain and 10 was the worst pain imagined) and did not affect his/her sleep or day-to-day activities.</p> <p>The care plan dated 10/22/15 indicated the resident had acute and chronic pain and directed staff to administer pain medication to alleviate pain.</p> <p>Review of the October 2015 electronic health record indicated the resident had a knee replacement in early 2015, fell at home, and</p>	F 309			

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F 309	<p>Continued From page 11</p> <p>sustained pain and swelling without damage to the new hardware. The resident admitted to the facility for rehabilitative services.</p> <p>Review of the clinical record revealed a pain assessment completed on admission dated 10/22/15, which indicated the resident had chronic pain and left knee pain, which the facility failed to rate.</p> <p>A written physician order dated 10/22/15 indicated to "continue with hospital medications."</p> <p>Review of the hospital discharge orders and signed hand-written physician orders dated 10/22/15 indicated Oxymorphone ER (extended release) (Opana ER) 20 mg (milligrams) 2 tablets by mouth twice daily and Oxymorphone ER (Opana ER) 10 mg 1 tablet by mouth twice daily.</p> <p>Review of the hand-written October 2015 medication administration record (MAR) revealed the facility failed to transcribe the order for Oxymorphone ER (Opana ER) 20 mg (milligrams) 2 tablets by mouth twice daily. The facility failed to administer this medication to the resident.</p> <p>Review of the October 2015 MAR revealed staff administered the resident Oxymorphone ER (Opana ER) 10 mg 1 tablet by mouth on 10/22/15 at 8:00 P.M., 10/23/15 at 8:00 A.M., 10/24/15 at 8:00 A.M., and 10/25/15 at 8:00 A.M.</p> <p>The October 2015 MAR lacked documentation of the administration of the 8:00 P.M. dose of Oxymorphone ER (Opana ER) 10 mg 1 tablet by mouth as ordered by the physician on 10/23/2016 and 10/24/2016.</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>Review of the signed hand-written physician's order sheet dated 10/22/15 revealed an order for Morphine IR (immediate release) 15 mg (milligrams) PO (by mouth) every 4 hours PRN (as needed).</p> <p>Review of the hand-written October 2015 MAR revealed the resident was administered Morphine IR 15 mg PO on 10/23/15 at 4:15 P.M. and on 10/24/15, the resident received 6 doses morphine IR 15 mg PO. The MAR was illegible and the times of administration for the morphine IR were not determined.</p> <p>The clinical record lacked documentation of narcotic (controlled medications) sign out sheets for resident #82.</p> <p>The clinical record lacked documentation of a pain assessment before and after administration of the PRN pain medication Morphine IR 15 mg PO 7 out of 7 times staff administered the medication.</p> <p>A discharge note dated 10/25/15 and timed 1:36 P.M. indicated staff spoke to the physician on-call and obtained a discharge order per family member request. Staff reviewed the medication list with a family member and identified the resident had received Oxymorphone ER (Opana ER) 10 mg twice daily rather than the total 50 mg twice daily as ordered.</p> <p>During an interview on 3/22/16 at 4:35 P.M. administrative nursing staff E reviewed the clinical record, verified the MAR did not contain the order for Oxymorphone ER (Opana ER) 20 mg 2 tablets by mouth twice daily as ordered by the</p>	F 309			

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F 309	Continued From page 13 physician, and stated a transcription error was made by the facility. Administrative nursing staff E stated the MAR was not legible and he/she and could not verify the times of PRN dose administration. Staff E said he/she expected licensed staff to assess pain before and after medication administration and to document the effectiveness of the medication. During an interview on 3/22/16 at 5:20 P.M. with the resident's family member, he/she stated the resident experienced an extreme amount of pain and withdrawal symptoms from 10/22/15 through 10/25/15 since the correct dose of Oxymorphone ER 50 mg twice daily had not been administered as prescribed. The family member stated the resident was taken to his/her physician at the pain management clinic after discharge to be tritrated back to his/her normal pain medication regime. The facility provided policy General Dose Preparation and Medication Administration dated 12/1/07 and a revision date of 1/1/13 directed staff to document necessary medication administration information on appropriate forms. The facility failed to administer physician ordered pain medication, monitor and assess pain, and manage this resident's chronic pain.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314			

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F 314	<p>Continued From page 14</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 31 residents and the sample was 21. Based on observation, interview, and record review, the facility failed to assess/monitor, prevent, and promote healing of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for two of three residents (#36, #34) sampled for pressure ulcers, and failed to identify the presence of a physician documented pressure ulcer for one of three residents (#60) sampled for pressure ulcers.</p> <p>- Findings included:</p> <p>- Review of resident #36's unsigned electronic medical record dated 8/27/15 documented the following diagnoses: pressure ulcer of the heel, nondisplaced fracture of the right fibula (break of the outer/smaller bone between the knee and ankle), muscle weakness, and muscle atrophy (wasting or decrease in size of a part of the body).</p> <p>Review of the admission MDS (Minimum Data Set) dated 8/18/15 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated intact cognition. The resident required extensive assistance of two staff with bed mobility, transfers, dressing, and toileting; did not walk; extensive assistance of one staff with</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2016
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F 314	<p>Continued From page 15</p> <p>locomotion on and off the unit; setup assistance for eating; and supervision of one staff with personal hygiene. The resident was at risk for pressure ulcers, and had one unstageable pressure ulcer (deep tissue injury) present on admission, which measured 2.0 cm (centimeters) x 2.0 cm.</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 2/16/16 documented a BIMS score of 15, which indicated intact cognition. The resident required extensive assistance of one staff with bed mobility, dressing, and personal hygiene; extensive assistance of two staff with transfers and toileting; did not walk; supervised setup assistance with locomotion on and off the unit; and setup help with eating. The resident was at risk for pressure ulcer development, had one unstageable pressure ulcer, present on admission, which measured 0.5 cm x 0.5 cm.</p> <p>Review of the Activities of Daily Living (ADL) CAA (Care Area Assessment) dated 8/18/15 documented the resident had ADL deficits secondary to a recent hospitalization with increased weakness and he/she required extensive assistance with self-care, transfers, and toileting.</p> <p>Review of the Pressure Ulcer CAA dated 8/18/16 documented the resident was at high risk for skin breakdown due to decreased mobility and he/she had a pressure wound on his/her heel.</p> <p>Review of the resident's care plan dated 11/16/15 documented the resident had an unstageable pressure ulcer to the left lower heel. The care plan directed licensed staff to perform weekly skin assessments and for the wound doctor to</p>	F 314			

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F 314	<p>Continued From page 16</p> <p>assess and make treatment recommendations weekly.</p> <p>Weekly skin assessments by the licensed staff were documented on 8/18/15, 8/26/15, 9/2/15, 9/16/15, 10/7/15, 10/14/15, 10/28/15, 11/25/15, 12/9/15, 12/16/15, 12/25/15, 1/1/16, 1/11/16, 2/24/16, and 3/9/16.</p> <p>The medical record lacked documentation of weekly skin assessments on 9/9/15, 9/23/15, 9/30/15, 10/21/15, 11/4/15, 11/11/15, 11/18/15, 12/2/15, 1/8/16, 1/22/16, 1/29/16, 2/5/16, 2/12/16, 2/19/16, and 3/2/16.</p> <p>Weekly wound evaluations by the wound physician were documented on 8/14/15, 8/21/15, 8/28/15, 9/4/15, 9/11/15, 9/18/15, 9/25/15, 10/2/15, 10/20/15, 10/28/15, 11/4/15, 11/12/15, 11/13/15, 11/20/15, 11/27/15, 12/4/15, 12/11/15, 12/18/15, 1/15/16, 1/22/16, 1/29/16, 2/5/16, 2/12/16, 2/19/16, 2/26/16, and 3/4/16.</p> <p>The medical record lacked documentation of weekly wound evaluations on 10/9/15, 10/16/15, 12/25/15, 1/1/16, 1/18/16, and 3/11/16.</p> <p>The physician order dated 8/11/15 directed staff to elevate the resident's heels in bed with pillows to relieve pressure.</p> <p>The physician order dated 9/25/15 directed staff to perform weekly skin assessments.</p> <p>During an observation on 03/21/2016 at 2:30 P.M. the resident slept in his/her motorized wheelchair with both heels positioned on a pillow on the bed. The resident's heels were not relieved from pressure.</p>	F 314			

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F 314	Continued From page 17 During an observation on 03/22/2016 at 9:02 A.M. the resident laid in bed with a pillow under his/her heels (not relieved from pressure), a pressure reducing mattress, and a cushion in the motorized wheelchair. Licensed staff H washed his/her hands, put on gloves, removed the resident's sock, and rubbed skin prep to the wound. He/she placed the left heel back on the pillow (not relieved from pressure) with the sock off at the resident's request. The wound had a nickel sized, circular black area. Licensed staff H stated the wound had not drained and waited for the scab to come off. During an interview on 03/22/2016 at 9:02 A.M. the resident stated his/her heel wound developed from the placement of a boot on his/her foot prior to coming to the facility. During an interview on 03/21/2016 at 4:56 P.M. direct care staff W stated he/she looked in the electronic charting for any needed information about a resident and also asked the nurses. He/she informed the resident was not on a repositioning schedule, was able to move him/herself in the chair, and needed help with moving his/her feet. Staff W said the resident had a healed wound on the left heel. During an interview on 03/22/2016 at 12:44 P.M. licensed staff H stated nurses did weekly skin assessments and the wound doctor assessed the wound weekly. During an interview on 03/22/2016 at 4:03 P.M. administrative nursing staff E stated nursing staff did a full body assessment weekly and a weekly note should be placed in the chart and the wound	F 314			

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F 314	<p>Continued From page 18</p> <p>doctor did weekly assessments. He/she said the nursing staff documented a weekly note separate from the wound physician's assessment and was in the treatment administration record or the electronic charting.</p> <p>The undated Skilled Nursing Standards of Performance Skin Care Management policy documented licensed nursing staff and the director of nursing administration (DNA) completed weekly wound updates and skin checks for all guests/residents and weekly wound rounds were done with the clinical team, led by the DNS, to assess wound progress and determine the response to the current treatment plan.</p> <p>The facility failed to complete weekly skin assessments and implement interventions to promote wound healing for this resident who admitted with a pressure ulcer.</p> <p>- Review of resident #34's signed Physician's Order Sheet (POS) dated 1/29/16 revealed a diagnosis of heart failure.</p> <p>Review of the Admission MDS dated 2/2/16 documented the resident had a BIMS(Brief Interview for Mental Status) score of 13, which indicated intact cognition. The resident required extensive assistance of one staff with bed mobility, locomotion off the unit, dressing, toileting, and personal hygiene; extensive assistance of two or more staff with transfers; limited assistance of one staff with walking in room; walking in corridor did not occur; locomotion on the unit only occurred once or twice with one staff assistance; and supervision of setup only with eating. The resident was at risk</p>	F 314			

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F 314	<p>Continued From page 19 for pressure ulcers and had no pressure ulcers on admission.</p> <p>Review of the ADL (activities of daily living) CAA (Care Area Assessment) dated 2/2/16 documented the resident had ADL deficits related to a recent acute illness and hospitalization due to cardiac issues, which left him/her weak with activity intolerance.</p> <p>Review of the Pressure Ulcer CAA dated 2/2/16 documented the resident was at increased risk for skin breakdown due to decreased mobility. He/she had a history of pressure ulcers and no current pressures ulcers.</p> <p>The Care plan dated 1/26/16 documented the resident had an increased risk for skin breakdown due to decreased mobility, incontinence, and dry fragile skin. On 2/11/16 the care plan documented the resident had a small open area on the buttock, which was at the site of a prior open area when hospitalized. The care plan directed the doctor to assess weekly and facility staff to complete weekly skin checks.</p> <p>Review of the medical record dated 1/26/16 through 3/17/16 documented one skin assessment dated 2/12/16.</p> <p>Review of the medical record dated 1/26/16 through 3/17/16 documented weekly wound evaluations by the wound physician on 1/26/16, 2/12/16, 2/26/16, 3/4/16, and 3/11/16 for the wound on the right buttock.</p> <p>The medical record lacked a documented wound assessment by the physician on 2/19/16.</p>	F 314			

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F 314	<p>Continued From page 20</p> <p>The resident discharged and was not interviewed or observed.</p> <p>During an interview on 03/21/2016 at 4:56 P.M. direct care staff W stated he/she looked in the electronic charting for any needed information about a resident and also asked the nurses. On 03/21/2016 at 5:06 P.M. he/she stated the resident had an open wound on his/her bottom, which healed prior to his/her discharge.</p> <p>During an interview on 03/22/2016 at 12:44 P.M. licensed staff H stated nurses do weekly skin assessments and the wound doctor assessed the wound weekly.</p> <p>During an interview on 03/22/2016 at 4:03 P.M. administrative nursing staff E stated nursing staff did a full body assessment weekly and a weekly note should be placed in the chart and the wound doctor did weekly assessments. He/she said the nursing staff documented a weekly note separate from the wound physician's assessment and was in the treatment administration record or the electronic charting.</p> <p>The undated Skilled Nursing Standards of Performance Skin Care Management policy documented licensed nursing staff and the director of nursing administration (DNA) completed weekly wound updates and skin checks for all guests/residents and weekly wound rounds were done with the clinical team, led by the DNS, to assess wound progress and determine the response to the current treatment plan.</p> <p>The facility failed to complete weekly skin assessments for this resident with a pressure</p>	F 314			

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F 314	<p>Continued From page 21 ulcer.</p> <p>- Review of resident #60's signed physician order sheet dated 10/6/15 documented the following diagnoses: peripheral arterial insufficiency of the lower extremities (an abnormal condition of the circulation of blood vessels) and cellulitis to the right lower extremity (a skin infection of the local tissues characterized by heat, redness and swelling). The signed physician order sheet dated 10/9/15 documented 2 unhealed wounds in the right foot related to cellulitis and a diagnosis of gangrene (tissue death) of the right 4th and 5th toes.</p> <p>Review of the admission MDS (Minimum Data Set) dated 10/12/15 documented a BIMS (Brief Interview for Mental Status) score of 13, which indicated intact cognition. The resident needed extensive assistance of 2 staff for bed mobility, and transfers; assistance of 1 staff for locomotion on/off the unit, walking in the room, dressing, toileting, and bathing; and set-up assistance for eating. The resident had no pressure ulcers and had 2 venous or arterial ulcers (wounds caused by poor circulation). Staff provided the resident a pressure-reducing devices for his/her chair and bed and a turning/repositioning program.</p> <p>Review of the ADL (Activities of Daily Living) CAA (Care Area Assessment) dated 10/12/15 revealed a self-care deficit related to weakness, dyspnea (shortness of air), poor balance and cognitive deficits.</p> <p>Review of the Pressure Ulcer CAA dated 10/12/15 revealed the resident was at risk for tissue breakdown or injury related to decreased mobility and incontinence. He/she had wounds on</p>	F 314			

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F 314	<p>Continued From page 22</p> <p>his/her lower legs related to arterial stasis and had a history of peripheral vascular disease with a potential for poor healing.</p> <p>Review of the Braden Risk Assessment scores dated 10/12/15, 10/19/15 and 10/26/15 recorded a score of 15, which indicated the resident was at risk for the development of pressure ulcers.</p> <p>Review of the resident's care plan dated 10/6/15 directed staff to provide 2 staff assistance with ADL's to include bed mobility and transfers and provide 1 staff assistance with locomotion on/off the unit, walking in the room, dressing, toileting and bathing. Staff revised the care plan on 10/12/15 and directed staff to assess and document wound healing, monitor for worsening of symptoms, and treat wounds in the resident's lower legs as ordered.</p> <p>Review of the resident's wound clinic notes dated 10/9/15 and 10/16/15 documented some of the resident's wounds were stasis ulcers or blisters and one wound on the bottom of the right foot was recorded as a stage 2 shear and pressure related wound. The wound was documented as open on 10/9/15 and remained open per physician's progress noted dated 10/16/15.</p> <p>An admission skin assessment dated 10/15/2015 documented the resident had open blisters on the top and bottom of his/her right foot . The top wound was open and the bottom wound was closed.</p> <p>Review of physician orders dated 10/19/15 documented the following orders for wounds to the right lower leg and right top foot: cleanse the wounds with wound cleanser, apply Vaseline</p>	F 314			

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F 314	<p>Continued From page 23</p> <p>gauze to the wound bed, cover with an ABD pad (highly absorbent dressing that provides padding and protection for large wounds), secure with Kerlex (a dry dressing) and tape. Cleanse the right bottom foot with wound cleanser and apply skin prep (a protective barrier) daily.</p> <p>The physician's orders dated 10/24/15 directed staff to paint all wounds with Betadine (an antiseptic), cover with ABD pads, wrap with Kerlex, adhere with tape, and change daily and as needed.</p> <p>The resident discharged on 10/29/15 and was not observed or interviewed.</p> <p>During an interview on 3/22/16 at 4:02 P.M. licensed staff L said the resident had a combination of problems and complications from cellulitis and stasis ulcers. He/she did not recall the specifics about the resident's wound care from 10/2015 or his/her assessments.</p> <p>During an interview on 3/21/16 at 5:22 P.M. administrative nursing staff D said the resident's wounds were related to arterial insufficiency and cellulitis and the resident had no pressure ulcers.</p> <p>During an interview on 3/21/16 at 8:22 A.M. administrative nursing staff E said he/she completed resident assessments (MDS) with a combination of information gathered from direct observation, direct care staff, licensed care staff and the medical record.</p> <p>During an interview on 3/22/2016 at 1:12 P.M. staff E said the resident did not have pressure ulcers and his/her wounds were specifically related to stasis and cellulitis. Staff E said the</p>	F 314			

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F 314	Continued From page 24 wound doctor sometimes labeled wounds as pressure ulcers, but in this case the wounds were not pressure ulcers. During an interview on 3/22/15 at 3:29 P.M. administrative staff E said he/she tried to accurately document assessments as possible and used documentation from direct care staff, licensed staff, record review, and physical therapy. Review of the undated Skilled Nursing Standards of Performance of Skin Care Management policy documented licensed staff assessed the resident's skin every shift during the first 24 hours and documented findings in the Health and Service Evaluation assessment, initiated a treatment plan for identified skin problems, and implement treatments as ordered by the physician. The facility failed to identify, monitor, implement interventions, and assess a physician documented pressure ulcer for this resident at risk for pressure ulcers.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2016
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
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F 323	<p>Continued From page 25</p> <p>by:</p> <p>The facility identified a census of 31 residents. The sample included 21 residents. Based on observation, interview, and record review the facility failed to thoroughly investigate and implement timely interventions to prevent further falls for 1 of 3 resident's reviewed for accidents. (#74)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The signed physician's order sheet for resident #74 dated 01/17/2016 revealed the diagnoses of Parkinson's Disease (a degenerative disorder of the central nervous system, which affected the motor system), benign prostatic hyperplasia (enlargement of the prostate), pain, spinal stenosis (an abnormal narrowing of the spinal canal, which resulted in a neurological deficit), chronic urinary tract infection, and constipation (difficulty with bowel movements). <p>Review of the 30 day Minimum Data Set (MDS) dated 02/13/16 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated a moderate cognitive impairment. The resident required assistance of one staff with bed mobility, transfers, locomotion on/off the unit, personal hygiene, bathing, and dressing and two staff assistance with toileting.</p> <p>Review of the care plan dated 02/8/2016 identified the resident as a fall risk due weakness, low endurance, cognitive deficits, and Parkinson's Disease. The resident fell on 1/18/2016 and twice on 2/18/2016. The care plan directed staff keep the call light within reach, remind/encourage him/her to use the call light and request staff assistance as he/she needed, although because</p>	F 323			

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F 323	<p>Continued From page 26</p> <p>of cognitive impairment he/she may not remember to use the call light, make frequent visual checks to assure safety and assess the resident's needs, encourage and assist to activities which promoted exercise, ensure appropriate foot wear, provide verbal reminders to avoid reaching down on the floor to pick up objects, and staff adjusted the resident's wheelchair to prevent him/her from leaning forward.</p> <p>Review of a fall assessment dated 01/17/2016 documented the resident fell within the past 30 days, had an unsteady gait, medication regimen changes, used assistive devices, made unsafe transfers, was incontinent, and had Parkinson's disease.</p> <p>Review of a fall investigation dated 02/18/2016 at 1:30 P.M. documented staff found the resident on the floor by the bathroom door lying on his/her left side. The fall was unwitnessed and the resident said he/she tried to walk. Staff educated the resident to avoid self attempts to transfer and moved the resident to an activity room for safety.</p> <p>Review of a fall investigation dated 02/18/16 at 10:07 P.M. document the resident sat in the activities room across from the nurse's desk and leaned forward reaching towards his/her shoe. The nurse assisted the resident to an upright position, and walked away. The resident leaned forward again and fell. Staff assisted the resident to bed and he/she watched the television with no further attempts to get up.</p> <p>Review of a fall investigation dated 03/07/2016 at 08:15 A.M. documented the resident had an unwitnessed fall in the bathroom and staff found</p>	F 323			

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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
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F 323	Continued From page 27 him/her lying in his/her side. The resident said he/she tried to get off the toilet, wore proper non-skid foot wear, and was dry. The resident had attempted to transfer him/herself from the wheelchair to the toilet. Staff last saw the resident at 8:00 A.M. in the bathroom washing his/her face. The investigation lacked an analysis of findings, which failed to identify an intervention to prevent further falls. During an observation on 3/16/2016 at 11:14 A.M. the resident sat in a wheelchair in his/her room. The resident had a fall mat at bedside and a reacher available to obtain items off the floor or dresser. During an interview on 3/21/2016 at 5:38 A.M. direct care staff V stated staff checked on the resident on a frequent basis, was incontinent of stool, had gotten up early that day, and staff made sure the resident was clean and dry. During an interview on 3/7/2016 at 8:33 A.M. administrative staff E said when an incident occurred a new intervention was added to the care plan and this needed work. He/she nursing staff could add an immediate intervention after an incident and confirmed the facility had not updated an intervention after the resident's last fall. The facility failed to thoroughly investigate and implement interventions to prevent further falls for this cognitively impaired resident who had 3 falls in the past 3 months.	F 323			
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364			

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F 364	<p>Continued From page 28</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 31 residents and the sample was 21. Based on observation, interview, and record review the facility failed to serve food to residents at the proper temperature on 1 of 4 days of the survey.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - During an observation and interview on 03/16/2016 at 4:50 P.M. dietary staff FF took temperatures of the dinner meal prior to serving. The roasted cauliflower temperature was 135 degrees F (Fahrenheit) and staff failed to check the temperature of the hamburger patties or the pureed bread. Dietary staff FF stated staff should check all food temperatures. <p>During an observation and interview on 03/16/2016 at 5:09 P.M. dietary staff GG performed food temperature checks after the food was transported from the kitchen to this kitchenette. The roasted cauliflower temperature was 122 degrees F, pureed chicken was 129-130 degrees F, pureed bread was 112 degrees F, and the gravy was 130 degrees F. Dietary staff GG stated the pureed chicken needed warmed so he/she let it sit longer on the steam table and planned to perform another temperature check before serving. He/she said the food could be heated in the microwave if needed. He/she stated</p>	F 364			

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F 364	<p>Continued From page 29</p> <p>the pureed bread could be warmer, but it was just bread, so it could be served at room temperature.</p> <p>During an observation and interview on 03/16/2016 at 5:40 P.M. dietary staff GG served pureed chicken, Shepard's pie, roasted cauliflower, mashed potatoes, and gravy without checking the temperature. He/she acknowledged a temperature check was not done before serving the food.</p> <p>During an interview on 03/21/2016 at 5:29 P.M. dietary staff DD stated he/she expected food to be heated 145 to 165 degrees. If the food was not hot enough staff should send the food back to the kitchen for reheating and then served.</p> <p>During an interview on 03/22/2016 at 10:19 A.M. dietary staff EE stated staff normally get a temperature on each compartment of food before serving and he/she expected food to be above 140 degrees on the steam table and if the food was not hot enough he/she expected the staff to bring the food to the kitchen, and reheat to the correct temperature. He/she stated roasted cauliflower and vegetables should be above 120 degrees as they get mushy easily.</p> <p>The Food Temperatures policy dated 1/1/2014 documented staff reheated food to the proper temperature if temperatures did not meet acceptable serving temperatures. Foods such as gravy, casseroles, meat entrees, potatoes, soup, pureed foods, and vegetables were to be at a temperature greater than or equal to 140 degrees, but preferably between 140-165 degrees.</p> <p>The facility failed to check food temperatures and</p>	F 364			

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F 364	Continued From page 30 heat to the appropriate temperature prior to serving.	F 364			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility identified a census of 31 residents. Based on observation, interview, and record review the facility failed to store, prepare, and serve food under sanitary conditions in one kitchen during 3 of 4 days. Findings included: - During an observation and interview on 3/15/2016 at 9:05 A.M. the dry storage in the main kitchen had a box of open pie crust, which was uncovered and undated, vanilla wafers and light molasses, which were opened and undated. The main freezer had one bag of vegetables and one bag of noodles opened and undated. The kitchen refrigerator on the unit had milk, which was opened and undated and ice cream in the freezer opened and undated. Dietary staff DD stated uncovered food should be wrapped and all opened foods should be dated when opened.	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2016
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F 371	Continued From page 31 During an observation on 03/15/2016 at 12:30 P.M. staff handled two small serving plates, touched the food on the plates, and placed them on the table. During an interview on 03/15/2016 at 1:41 P.M. direct care staff M stated staff were instructed to handle plates on the underneath surface of the plate and not over the top of foods. During an observation on 03/16/2016 at 4:00 P.M. kitchen staff entered the kitchen food preparation area without securing his/her hair with a hairnet. During an observation and interview on 03/16/2016 at 4:04 P.M. a staff member had facial hair and wore no beard guard. Dietary staff EE stated all hair must be covered with hairnets and worn upon entrance to the kitchen. He/she said beard guards were worn for facial hair, which measured 2 inches in length. During an observation on 03/16/2016 at 4:55 P.M. an unidentified person came in to the kitchen, went into the refrigerator, got a soda, and did not wear a hairnet. During an observation and interview on 03/16/2016 at 5:00 P.M. a personal cell phone laid on a cutting board in the kitchen. Dietary staff FF stated the cell phone should not be placed there. During an observation and interview on 03/16/2016 at 5:04 A.M. dietary staff GG had facial hair, and he/she stated he/she was not instructed to wear a beard guard for facial hair.	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2016
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F 371	<p>Continued From page 32</p> <p>During an observation on 03/21/2016 at 9:16 A.M. a staff member wore a hairnet, which did not fully restrain and cover the front of his/her hair.</p> <p>During an interview on 03/21/2016 at 5:29 P.M. dietary staff DD stated staff were expected to pick up plates from the side without touching food. He/she expected all staff to wear hairnets and expected beard guards to be worn if the staff had more than a small amount of facial hair.</p> <p>During an interview on 03/22/2016 at 10:19 A.M. dietary staff EE stated he/she preferred staff did not have their cell phones in the food preparation area.</p> <p>The facility's Dining Room Service policy dated 7/1/2014 documented eating surfaces of plates should not come in contact with staff clothing or hands.</p> <p>The facility's Personal Hygiene policy dated 9/4/2015 documented hair must be appropriately restrained or completely covered by a clean hat or other hair restraint and beards must be covered.</p> <p>The facility failed to provide a policy regarding personal items in the kitchen area as requested.</p> <p>The facility failed to properly store, serve, and distribute food and failed to provide a sanitary food environment by keeping personal items out of the food preparation area.</p> <p>- During an observation on 3/15/16 at 12:31 P.M. direct care staff Q poured water into a glass and touched the rim of the glass with the water pitcher.</p>	F 371			

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F 371	Continued From page 33 During an observation on 3/15/16 at 12:37 P.M. dietary manager DD poured apple juice from a pitcher and touched the rim of the glass with the pitcher. During an interview on 3/15/16 at 1:32 P.M. direct care staff Q said staff should not touch the rim of a glass with a pitcher when fluids were poured. During an interview on 3/15/16 at 2:08 P.M. dietary manager DD said it was incorrect and unsanitary when staff touched the rim of a glass with the pitcher when fluids were poured and this was not according to policy. Review of the facility Dining Room Service policy dated 7/1/14 directed staff to follow correct and sanitary food service practices. The facility failed to provide sanitary food service according to policy.	F 371			
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by:	F 386			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 386	<p>Continued From page 34</p> <p>The facility identified a census of 31 residents. The sample included 21 residents. Based on observation, record review, and interview, the facility failed to ensure order sheets were signed by the physician for two residents (#2, #50).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #2's annual history and physical dated 4/15/15 indicated diagnoses of Alzheimer ' s dementia (progressive mental deterioration characterized by confusion and memory failure) and failure to thrive. <p>Review of the significant change minimum data set (MDS) dated 12/14/15 revealed a brief interview for mental status (BIMS) score of 1, which indicated severely impaired cognition. During assessment, the resident received antidepressant medication for 4 days.</p> <p>Review of the quarterly minimum data set (MDS) dated 3/15/16 revealed a staff assessment of mental status which indicated severely impaired cognition. During assessment, the resident received antianxiety medication for 7 days and an antibiotic for 6 days. The resident was receiving hospice services.</p> <p>The care area assessment (CAA) for psychotropic drug use dated 12/14/15 indicated the resident received Remeron (a medication used to treat depression) for a short time but it was discontinued per family request when the resident was placed on hospice.</p> <p>The care plan dated 4/15/14 and revised on 3/15/16 identified the resident was on hospice services and was monitored for black box</p>	F 386			

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F 386	<p>Continued From page 35</p> <p>warnings (a warning issued by the FDA (US food and drug administration) of serious or life-threatening risks located on the label of a prescription drug) and psychotropic medication use.</p> <p>The clinical record lacked a physician signature on the physician's order sheet for December 2015, February 2016, and March 2016.</p> <p>Interview on 3/22/16 at 4:22 P.M. with administrative nursing staff E revealed physician order sheets should be signed monthly.</p> <p>The facility provided policies regarding medication lacked direction to staff for ensuring order sheets contained a physician signature.</p> <p>The facility failed to ensure physician order sheets were signed monthly by the physician.</p> <p>- Review of resident #50's 2016 electronic health record indicated diagnoses of dementia with Lewy bodies (a progressive mental disorder characterized by failing memory and confusion and abnormal protein deposits in the brain that cause Parkinsonian symptoms such as resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).</p> <p>Review of the admission minimum data set (MDS) dated 11/14/15 revealed a staff assessment of mental status, which indicated severely impaired cognition. During assessment, the resident received antipsychotic medication for 7 days and antianxiety medication for 1 day.</p> <p>Review of the quarterly minimum data set (MDS) dated 2/14/16 revealed a brief interview for</p>	F 386			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2016
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F 386	<p>Continued From page 36</p> <p>mental status (BIMS) score of 3 which indicated severely impaired cognition. During assessment, the resident received antipsychotic medication for 7 days.</p> <p>The care area assessment (CAA) for psychotropic drug use dated 11/14/15 indicated the resident had a potential for adverse effects of the daily use of the antipsychotic medication Seroquel for aggression associated with a mood disorder.</p> <p>The care plan dated 11/4/15 and revised 2/16/16 identified monitoring for black box warnings (a warning issued by the FDA (US food and drug administration) of serious or life-threatening risks located on the label of a prescription drug) and psychotropic medication use.</p> <p>The clinical record lacked a physician signature on the physician's order sheet from admission on 11/2/15 through 3/22/16.</p> <p>The facility provided policies regarding medication lacked direction to staff for ensuring order sheets contained a physician signature.</p> <p>Interview on 3/22/16 at 6:55 A.M. with licensed nursing staff H revealed physician order sheets should be signed monthly.</p> <p>During an interview on 3/22/16 at 4:22 P.M. with administrative nursing staff E, he/she reviewed the clinical record with the surveyor and confirmed the physician had never signed the order sheet since the resident had been admitted in November 2015. Administrative nursing staff E stated the physician order sheets should be signed monthly.</p>	F 386			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2016
FORM APPROVED
OMB NO. 0938-0391

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F 386	Continued From page 37	F 386			
F 425 SS=D	<p>The facility provided policies regarding medication lacked direction to staff for ensuring order sheets contained a physician signature.</p> <p>The facility failed to ensure physician order sheets were signed monthly by the physician.</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 31 residents. The sample included 21 residents. Based on observation, record review, and interview, the facility failed to accurately transcribe medication</p>	F 425			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/25/2016
NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
(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 425	<p>Continued From page 38</p> <p>orders for 1 (#82) of 5 residents reviewed for unnecessary medications.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #82's 2015 electronic health record indicated diagnoses of back pain, left knee effusion (excess fluid that accumulates in or around the knee joint) and depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness, and hopelessness). <p>Review of the admission (5-day) minimum data set (MDS) dated 10/25/16 revealed a brief interview for mental status (BIMS) score of 13 which indicated intact cognition. The resident received scheduled pain medication, PRN (as needed) pain medication, and non-medication intervention for pain. The resident identified his/her pain occurred frequently at a scale of 9 but did not affect sleep or day-to-day activities.</p> <p>The care plan dated 10/22/15 indicated the resident had acute and chronic pain with intervention to administer pain medication to alleviate pain.</p> <p>A written order dated 10/22/15 indicated to "continue with hospital medications."</p> <p>Review of the hospital discharge orders dated 10/22/15 indicated Oxymorphone ER (extended release) (Opana ER) 20 mg (milligrams) 2 tablets by mouth twice daily and Oxymorphone ER (Opana ER) 10 mg 1 tablet by mouth twice daily.</p> <p>Review of the hand-written October 2015 medication administration record (MAR) revealed</p>	F 425			

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F 425	Continued From page 39 the facility failed to transcribe the order for Oxymorphone ER (Opana ER) 20 mg (milligrams) 2 tablets by mouth twice daily. A discharge note dated 10/25/15 and timed 1:36 P.M. indicated staff spoke to the physician on-call and obtained a discharge order per family request. Staff reviewed the medication list with family and identified the resident had received Oxymorphone ER (Opana ER) 10 mg twice daily rather than the total 50 mg twice daily as ordered. During an interview on 3/22/16 at 4:35 P.M. administrative nursing staff E verified the MAR did not contain the order for Oxymorphone ER (Opana ER) 20 mg 2 tablets by mouth twice daily as ordered by the physician, and stated a transcription error was made by the facility. The facility provided policies regarding medication lacked direction to staff for transcription of orders. The facility failed to accurately transcribe medication orders for this resident with chronic pain.	F 425			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431			

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NAME OF PROVIDER OR SUPPLIER BRIGHTON GARDENS OF PRAIRIE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208		
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F 431	<p>Continued From page 40</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. Based on observation, interview, and record review the facility failed to store medications and biologicals in a clean, safe and secure manner in 2 of 2 medication carts.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - During an observation on 3/15/16 at 9:01 A.M. medication cart #1 had 3 inhalers, which were open and undated to include; Fluticasone nasal inhaler (for treatment of breathing problems), 	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	<p>Continued From page 41</p> <p>DuoNeb inhaler (for the treatment of breathing problems) and Calcitonin nasal spray (for the treatment of osteoporosis or abnormal loss of bone density and deterioration of bone tissue).</p> <p>During an observation on 3/15/16 at 9:22 A.M. medication cart # 2 was left unlocked and unattended by licensed staff H. There were no residents in the area.</p> <p>During an observation on 3/15/16 at 9:26 A.M. medication cart #2 revealed 4 bottles of Milk-of-Magnesia (MOM) (medication for constipation) and each bottle had dried medication on the lid, spilled on the sides, and underneath all of the bottles.</p> <p>During an interview on 3/15/16 at 9:13 A.M. licensed staff J said all multi-use medication should be dated when opened.</p> <p>During an interview on 3/15/16 at 9:28 A.M. licensed staff I said the facility policy was to keep the medication cart locked when unattended. He/she said the medication cart should be kept clean and spills wiped.</p> <p>Review of the facility's Medication Administration and Medication Storage policies dated 12/1/07 revealed all medications should be dated when opened, medication carts should be attended at all times when unlocked, and medication carts should be kept in clean and sanitary conditions.</p> <p>The facility failed to store medications in a safe, secure and clean manner.</p>	F 431			