

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

Printed: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E577	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2013
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NAME OF PROVIDER OR SUPPLIER ANDERSON COUNTY HOSPITAL LTCU	STREET ADDRESS, CITY, STATE, ZIP CODE 421 S MAPLE ST-PO BOX 309 GARNETT, KS 66032
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F 000	<p>INITIAL COMMENTS</p> <p>The following citations represent the findings of a Health Resurvey.</p> <p>A revised copy of deficiencies was sent to the facility on 10/21/13.</p>	F 000		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 27 residents. Based on record review, observation, and interview, the facility failed to review and revise the plan of care with resident specific interventions for 2 residents including, #22 for dental cares and #26 for a wheelchair cushion used for positioning.</p>	F 280		

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 280	<p>Continued From page 1</p> <p>Findings include:</p> <ul style="list-style-type: none"> - The clinical record face sheet revealed resident #22 admitted to the facility on 1/4/13. <p>The admission MDS 3.0 (Minimum Data Set), dated 1/17/13, revealed the resident with a BIMS (Brief Interview of Mental Status) of 15 which indicates cognition intact, requires limited assistance with one staff for personal hygiene, receives a mechanically altered diet and has no natural teeth or tooth fragments.</p> <p>The CAA's (Care Area Assessment) for dental care, dated 1/17/13, revealed, "...the dentures do not fit the best and staff is encouraging use of denture cream to help with fit..."</p> <p>The care plan, dated 7/22/13, revealed staff are to encourage oral care BID (twice a day), has upper dentures and to assist with cares if requested... The plan failed to address the resident's loose fitting upper denture.</p> <p>Nutritional notes, dated 1/10/13, 4/9/13, 7/16/13 and 10/8/13, revealed that the resident required a mechanical soft diet and did not mention dental status.</p> <p>As of 10/16/13, the oral care completion chart revealed that oral care was provided BID for October 2013, with 2 evenings left blank.</p> <p>The initial interview nurses note, dated 1/4/13, revealed that the resident has upper dentures that do not fit well.</p> <p>On 10/14/13, at 9:42am, resident's top dentures are loose fitting and fall down throughout the conversation, held with the resident.</p>	F 280			

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F 280	<p>Continued From page 2</p> <p>On 10/15/13 at 10:38am, observation revealed residents upper teeth are not loose fitting today. They are staying in place.</p> <p>On 10/16/13, at 7:10am, observation revealed resident sitting in the wheelchair in his/her bedroom with upper dentures clean and without debris noted.</p> <p>Interview, on 10/15/13, at 10:39am, resident reports that the staff put some stuff in [his/her] dentures this morning and denies having any oral pain. Resident reported that their dentures are looser than before because [he/she] has lost weight since they got them and that at [his/her] age does not want to go to the dentist.</p> <p>On 10/15/13, at 3:43pm, activity/social service staff I reported, "When [staff A] or the other nurses tell me someone needs a dental appointment or needs to go to the dentist, I will make the appointment and transportation is provided to the dentist office." When asked if on admission staff I questions the resident and/or their family of their wishes on going to the dentist, staff I reported, "I do not ask them about their dental status. The nurses do that. As far as I know, [he/she] has not been to the dentist since [he/she] has been admitted here."</p> <p>On 10/16/13, at 10:29am, administrative nursing staff A revealed, "We try to get the resident to use the adhesive but [he/she]doesn't always like to use it though...The [family] or the resident have not mentioned any concerns about the residents dentures..."</p> <p>The facility failed to review and revise the plan of care to include resident specific interventions for</p>	F 280			

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F 280	<p>Continued From page 3 dental cares.</p> <p>- The medical record of resident #26 revealed the resident admitted on 05/17/2013, per the facesheet, and documented the diagnoses of Hemiplegia(paralysis of one side of the body) left side, debility (feebleness, weakness, or loss of strength) and muscle spasms.</p> <p>The admission MDS, dated 5/30/2013, documented the resident was admitted to the facility on 05/17/2013, BIMS(brief interview of mental status) of 15 which reveals cognitively intact, needs extensive assistance with bed mobility, transfers, locomotion on unit, and toilet use. His/her balance is not steady and has functional impairment on one side for upper and lower extremities.</p> <p>The CAA (Care assessment area) summary dated, 05/30/2013, for ADL (activity of daily living) documented the resident admitted from acute rehabilitation facility for post stroke and has left sided hemiparesis. At the present time he/she has no use of the left side and the staff uses a sit to stand lift for all transfers and he/she travels in a wheelchair that he/she can self propel with his/her right leg but requires encouragement to accomplish this...The staff is very cautious about repositioning/toileting as the resident is a high risk for pressure ulcer and falls related to inability to use left side. He/she is currently attending PT/OT(physical therapy and occupational therapy) and speech therapy...</p> <p>The care plan, dated 09/03/2013, for self care deficit related to CVA and left side hemiparesis as well as potential for injury related to weakness secondary to CVA and left side hemiparesis. The plan of care did not address the use of a saddle</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>wedge chair cushion for positioning and pressure relief.</p> <p>The Functional Maintenance Program note, dated 09/10/2013, documented wheelchair positioning currently for resident to have a comfort company saddle wedge in place. OT staff has also recommended that a comfort company saddle wedge quadragel (pad) be ordered by patients family to increase the resident's comfort in wheelchair...</p> <p>Observation, on 10/14/2013 at 4:10 PM, revealed resident positioned in a wheel chair in the dining room, conversing with a friend, his/her left arm in sling, left foot on foot pedal, no alarm in use, and the saddle wedge cushion in place.</p> <p>Observation, on 10/15/2013 at 7:13 am, revealed resident positioned in wheelchair awaiting breakfast, has cup of hot chocolate drink and a glass of ice water, appears alert, splint/brace and the saddle wedge cushion in place .</p> <p>Observation, on 10/16/2013 at 2:58 PM, revealed resident positioned in wheelchair sitting on the saddle wedge cushion..</p> <p>Observation, on 10/17/2013 at 8:30 am, Administrative nursing staff A could not produce a care plan containing information on the saddle wedge cushion.</p> <p>On 10/16/2013 at 10:26 am, Direct care staff D advised, "...He/she does want to be more mobile, but he/she is not physically able to get up on his/her own..."</p> <p>On 10/17/2013 at 8:30 am, Administrative nursing staff A advised, "The cushion in his/her chair was</p>	F 280			

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F 280	Continued From page 5 picked by OT for pressure relief in the chair. OT advised the family of what cushions would be beneficial for pressure relief to his/her bottom and the family purchased it. He/she has had the cushion since around mid-September... He/she has always had a pressure cushion in the chair for pressure relief. The present saddle cushion is not a restraint, it is for posture, and pressure relief. This resident is not physically capable of getting out of the chair on his/her own, but is always able to get to the call light. We make sure since he/she is unable to get up physically on his own. His call light is attached to the rail and on his/her lap while in his recliner or in wheelchair in his/her room. Every bed has pressure relieving mattress and if they are chair bound they have pressure relief cushions and those two things are always care planned. The facility failed to review and revise the plan of care to ensure the consistent provision of the saddle wedge cushion for this resident to prevent skin breakdown and maintain adequate positioning.	F 280		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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F 329	<p>Continued From page 6</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 27 residents, with five selected for review of unnecessary medications. Based on record review, observation, and interviews, the facility failed to ensure freedom from unnecessary medications related to failure to adequately monitor 1 of these 5 residents (#26) for adverse consequences of medications with black box warnings.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The medical record of resident #26 revealed the resident admitted on 05/17/2013. The clinical record facesheet documented the diagnoses of Atrial fibrillation (rapid, irregular heart beat) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). <p>The physician's order documented a start date of 06/13/2013 for Celexa, 20 mg (milligrams), daily, PO, (by mouth), for depression.</p> <p>The MAR (medication administration record) documented the Celexa administered daily in July, August, and September, 2013.</p>	F 329		

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F 329	<p>Continued From page 7</p> <p>The physician's order documented a start date of 07/01/2013 for Coumadin, 3 mg, daily, PO, for clot prevention.</p> <p>The MAR documented the Coumadin administered daily in July, August, and September.</p> <p>The care plan, dated 09/03/2013, failed to the adverse effects of the black box warning for the Celexa or Coumadin.</p> <p>According to www.fda.gov <http://www.fda.gov>, Celexa had a black box warning of patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidally, or unusual changes in behavior.</p> <p>According to www.fda.gov <http://www.fda.gov>, Coumadin had a black box warning of bleeding risk. Coumadin can cause major or fatal bleeding. Perform regular monitoring of labs in all treated patients. Drugs, dietary changes, and other factors affect IN levels achieved with Coumadin therapy.</p> <p>On 10/15/2013 at 8:59 am, Direct care staff B advised, "The medications that have BBW's (black box warnings) are on a list that is printed out, it is not on the MAR. When the nurses enter a new order in to the computer it will flag a warning and they will not schedule with certain medications..."</p> <p>On 10/15/2013 at 10:00 am, Administrative nursing staff A advised, "I identify the medications and what they are used. The generic antidepressants and others with the black box warning, if they are the same, I assume you can</p>	F 329			

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F 329	<p>Continued From page 8</p> <p>figure out which one goes with what medication as they are identified in the care plan."</p> <p>On 10/16/2013 at 3:20 pm, Licensed nursing staff F advised, "For the black box warnings, I have to know if there is one for what drug they are taking and what the BBW is..., if it is a severe BBW you monitor what it says to watch for such as a skin rash. I do not know of any lists that are out here or if they are readily accessible. They are not marked on the MAR that I know of. They are no BBW in his care plan, as of today."</p> <p>On 10/16/2013 at 3:31 pm advised, Administrative staff A advised, "I do not have a black box warning for Celexa because he/she does not have dementia as a diagnosis. The Tylenol should have also had one."</p> <p>On 10/16/2013 at 4:30 pm, Administrative staff A advised, "I have identified the medications that need a black box warning and updated the careplan to include the medications such as Tylenol and a diuretic."</p> <p>On 10/17/2013 at 7:58 am, Licensed nursing staff G stated, "The medications with black box warnings are on the careplan and if we think we need to, we can look up in the drug book to see what side effects were possible. The BBW medications are addressed on the care plan."</p> <p>On 10/17/2013 at 9:30 am, Administrative Nursing Staff A advised, "They did a policy for black box warnings at this time."</p> <p>The facility failed to develop a system and plan of care to monitor the adverse consequences associated with the administration of these medications with black box warnings.</p>	F 329			

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F 428 F 428 SS=D	Continued From page 9 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by: The facility reported a census of 27 residents, with five selected for review of unnecessary medications. Based on record review, observation, and interviews, the facility consultant failed to identify the facility's failure to monitor resident #26 related to adverse consequences of medications with black box warnings. Findings included: - The medical record of resident #26 revealed the resident admitted on 05/17/2013. The clinical record facesheet documented the diagnoses of Atrial fibrillation (rapid, irregular heart beat) and depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). The physician's order documented a start date of 06/13/2013 for Celexa, 20 mg (milligrams), daily, PO, (by mouth), for depression. The MAR (medication administration record) documented Celexa was administered daily in	F 428 F 428		

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F 428	<p>Continued From page 10 July, August, and September, 2013.</p> <p>The physician's order documented a start date of 07/01/2013 for Coumadin, 3 mg, daily, PO, for clot prevention.</p> <p>The MAR documented Coumadin administered daily in July, August, and September, 2013.</p> <p>The care plan, dated 09/03/2013, failed to the adverse effects of the black box warning for the Celexa or Coumadin.</p> <p>According to www.fda.gov <http://www.fda.gov>, Celexa had a black box warning of patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidally, or unusual changes in behavior.</p> <p>According to www.fda.gov <http://www.fda.gov>, Coumadin had a black box warning of bleeding risk. Coumadin can cause major or fatal bleeding. Perform regular monitoring of labs in all treated patients. Drugs, dietary changes, and other factors affect IN levels achieved with Coumadin therapy.</p> <p>Electronic Pharmacy Consultant Recommendation dated 5/20/2013, 6/25/13/ 07/17/2013, 07/18/2013, 07/22/13, 08/17/203 and 09/25/2013 as having no recommendations on these dates.</p> <p>On 10/15/2013 at 10:00 am, Administrative nursing staff A advised, "I identify the medications and what they are used. The generic antidepressants and others with the black box warning, if they are the same, I assume you can, figure out which one goes with what medication as they are identified in the care plan."</p>	F 428			

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F 428	Continued From page 11 On 10/16/2013 at 3:20 pm, Licensed nursing staff F advised, "For the black box warnings, I have to know if there is one for what drug they are taking and what the BBW is..., if it is a severe BBW you monitor what it says to watch for such as a skin rash. I do not know of any lists that are out here or if they are readily accessible. They are not marked on the MAR that I know of. They are no BBW in his care plans as of today." On 10/17/2013 at 7:50 am Consultant E advised, "I have just overlooked the black box warnings, if I had seen it, I would of noted it as being a problem, but it will be addressed on my next visit." The Facility consulting staff failed to identify the facility's lack of monitoring of the medications with black box warnings for adverse consequences associated with the administration of these medication.	F 428		
F 431 SS=F	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. 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.	F 431		

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

Printed: 10/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E577	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/18/2013
NAME OF PROVIDER OR SUPPLIER ANDERSON COUNTY HOSPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 421 S MAPLE ST-PO BOX 309 GARNETT, KS 66032		
(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 431	<p>Continued From page 12</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 identified a census of 27 residents. Based on observation and interview, the facility failed to maintain a system to ensure accurate reconciliation and prevent exploitation of the residents medications.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 10/14/13 at 7:56 AM, observation of the medication storage in the facility medication room revealed, a locked cabinet with a slot for medications to be placed that have been discontinued or had a dosage change. In the cabinet were the following medications without documentation of reconciliation: <p>Potassium chloride, 10 meq, 28 pills Carvedilol, 12.5 mg, 23 pills Hydrochlorothiazide, 12.5 mg, 28 pills Verapamil, 120 mg, 22 pills</p>	F 431		

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F 431	<p>Continued From page 13</p> <p>Warfarin, 2 mg, 2 pills Citalopram, 20 mg, 28 pills Nitrofurantoin-macro, 100 mg, 3 tabs Quetiapine, 25mg, 21 pills Mucinex, 800mg, 2 pills Nitrofurantoin-macro, 100mg, 3 tabs Abilify, 5mg (1/2 tabs), 5 Tizanidine HCL, 2mg, 10 pills Carvedilol, 12.5mg, 22 tabs Verapamil, 120mg, 23 pills Hydrocodone/APAP (acetaminophen), 5-325mg, 7 pills</p> <p>In a second locked cabinet, were the following medications, without documentation of reconciliation:</p> <p>Lorazepam, 0.5mg, 31 pills Lorazepam, 0.5mg, 16 pills Hydrocodone/APAP, 5-325mg, 18 pills Hydrocodone/APAP, 5-325mg, 54 pills Hydrocodone/APAP, 5-325mg, 54 pills Hydrocodone/APAP, 5-325mg, 54 pills Hydrocodone/APAP, 5-325mg, 54 pills Iron, 325mg, 11 pills ASA, 81mg, 11 pills Plavix, 75mg, 11 pills Ocuvite, 11 pills Lasix, 20mg, 13 pills Lasix, 40mg, 11 pills Carvedilol, 6.25mg, 11 pills Carvedilol, 6.25mg, 9 pills Lisinopril, 40mg, 10 pills</p> <p>On 10/14/13 at 8:07 AM, licensed nursing staff H, reported that the licensed nurses have possession of the keys to the locked cabinets.</p> <p>On 10/16/13 at 7:45am, administrative nursing staff A, reports that the nurses should be</p>	F 431		

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F 431	<p>Continued From page 14</p> <p>recording the medications in the log book when the medications are pulled or discontinued. It does not appear that the nurses have been logging them. I will have it fixed in just a few minutes. He/she also stated that the medications range from 1 week to one month since staff put them in these cabinets (to be returned or destroyed). 9/19/13 was the order for the hydrocodone change and they (the pharmacist) must have just missed them with the last destroy that we did in September.</p> <p>The Returning Medications to Pharmacy policy, dated 10/18/04 reveals, "...For each medication returned, an entry is made on the medication return record. The medication return form is kept with the medications for return until picked up by the pharmacy. The receiving pharmacy staff signs the form to indicate receipt..."</p> <p>The facility failed to ensure that staff kept an accurate accounting of medications that were to be destroyed or returned to the pharmacy after a dosage change or discontinuation of medication.</p>	F 431		