STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175350	A. BUILDING _____ B. WING _____	C 09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #165060. The 2567 was electronically sent to the facility on 09/02/2021.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility had a census of 60 residents. The sample included three residents, with three reviewed for pain. Based on record review and interview, the facility failed to administer pain medication in a timely manner to one of three residents sampled, Resident (R) 1. Findings included: - R1's "Significant Change Minimum Data Set" (MDS), dated 08/28/20, documented the resident had severely impaired cognition, required extensive assistance of two staff for bed mobility, received scheduled and as needed pain medication for frequent, severe pain, and received hospice services. The "Quarterly MDS," dated 05/30/21, documented the same as Significant Change MDS except the resident had occasional pain. The "Pain Care Area Assessment" (CAA), dated 08/28/20, documented the resident had a recent	F 697		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/02/2021

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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exacerbation of pain with the need for an adjustment in pain medication to assist in maintaining comfort. The CAA further documented the resident had progressive cognitive and functional decline and admitted to supportive hospice services for end of life cares with a prognosis of six months or less.

The "Pain Care Plan," dated 06/17/21, directed staff to monitor and document the resident's pain level using an appropriate scale. Staff should also monitor and document relief obtained. The care plan further directed staff to provide pharmacological and non-pharmacological measures.

The "Hospice Care Plan," dated 06/17/21, directed staff to observe the resident for signs of pain, administer pain medications as ordered, notify physician immediately if there was breakthrough pain, and to provide maximum comfort for the resident.

The "Physician's Order," dated 08/20/20, directed staff to obtain hospice services for the resident.

The "Physician's Order," dated 09/04/20, directed staff to administer morphine sulfate (medication for moderate to severe pain), 0.25 milliliters (ml) by mouth every hour as needed for pain.

The "Physician's Order," dated 09/17/20, directed staff to administer Phenergan (medication to prevent and treat nausea, a queasy sensation including the urge to vomit), 25 milligram (mg) suppository (a medication placed in the rectum that melts to release medication) rectally (in the large bowel) every four hours as needed for nausea.

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The "Physician's Order," dated 09/17/20, directed staff to administer Zofran (medication used to prevent nausea and vomiting), 4 mg by mouth every four hours as needed for nausea.

The "Physician's Order," dated 03/04/21, directed staff to administer atropine sulfate Solution 1% (medication used to reduce saliva), two drops by mouth every two hours as needed for terminal secretions.

The "Physician's Order," dated 07/03/21, directed staff to administer Ativan (antianxiety medication used to calm and relax people with anxiety, nervousness, or tension), 0.25 ml by mouth every four hours as needed for anxiety.

The "Nurse's Note," dated 08/19/21 at 08:53 PM, documented staff administered Zofran, 4 mg and morphine sulfate, 0.25 ml to the resident.

The "Nurse's Note," dated 08/19/21 at 09:21 PM, documented the resident was restless and uncomfortable while lying in bed and staff administered Ativan 0.25 ml to the resident.

The "Nurses Note," dated 08/19/21 at 09:23 PM, documented the resident had two episodes of vomiting, which appeared to be partially digested food and pink in color due to a strawberry shake. The note further documented the medication aide reported to the nurse that Zofran was given by mouth and the resident vomited soon after. The noted documented staff administered a Phenergan suppository.

The "Nurses Note," dated 08/19/21 at 09:31 PM, documented staff administered Atropine Sulfate

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drops to the resident.

On 08/31/21 at 04:15 PM, Certified Medication Aide (CMA) R stated on 08/19/21 at 06:30 PM, over the walkie talkie, CMA S needed to go to the dementia unit to give the resident pain medication and that the resident had vomited. CMA R stated she was working in the Assisted Living and had to give the resident anti-nausea and pain medication around 09:00 PM because the resident did not receive medication for nausea and pain earlier, and the resident was crying.

On 08/31/21 at 04:50 PM, Certified Nurse Aide (CNA) M stated the resident had supper and did not feel well. Staff took the resident back to her room around 06:30 PM and as they started to lay the resident down, she vomited. CNA M further stated they used the walkie talkie to call the nurse to assess the resident. CNA M stated the nurse and Administrative Nurse D told CMA S to administer nausea and pain medication to the resident, but CMA S never came over to give the medication to the resident. The resident finally received medication around 09:00 PM (2 ½ hours after first request) after another CMA came and gave it to her. The resident was restless and in pain.

On 08/31/21 at 05:00 PM, Administrative Nurse D stated she was unsure of the time the staff called for medication for the resident but told CMA S to administer medication to the resident. Administrative Nurse D verified there was a delay in the resident receiving medication for nausea and pain.

On 09/01/21 at 09:15 AM, CMA S stated she was called to administer medication to the resident for

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nausea and pain around 06:30 - 07:00 PM on 08/19/21. CMA S stated she was in the middle of passing medication and forgot the resident needed medication. CMA S further stated staff called her again to give medications and she had other resident's medications on top of her cart and told the staff she would give the resident medications in a few minutes. CMA S stated another CMA went and gave the resident medication for pain and nausea.

The facility's "Administering Pain Medication," dated January 2021, directed staff to review the resident's care plan to assess for any special needs of the resident. The pain management program is based on a facility wide commitment to resident comfort. The resident with acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated after analgesic relief is obtained.

The facility failed to administer pain medication in a timely manner to R1, who received hospice service and had pain, placing the resident at risk for further pain and discomfort.