| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175555 | A. BUILDING _____ B. WING _____ | 06/02/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE HEALTHCARE RESORT OF TOPEKA | 6300 SW 6TH AVENUE TOPEKA, KS 66615 |

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| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00162228; KS00160838; KS00151426; KS00148155.<br><br>The 2567 was sent electronically to the faciltiy on 06/03/21. | F 000 | | |
| F 554 SS=D | Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)<br><br>§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.<br>This REQUIREMENT is not met as evidenced by:<br>The facility identified a census of 61 residents. The sample included 19 residents. Based on observations, record reviews, and interviews, the facility failed to ensure safe and appropriate self-administration of medication for Resident (R) 18.<br><br>Findings included:<br><br>- R18 admitted to facility 09/30/17.<br><br>The "Diagnoses" tab of R18's electronic medical record (EMR) documented diagnoses of fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), rheumatoid arthritis (RA- chronic inflammatory disease that affected joints and other organ systems), and pain in left shoulder.<br><br>The "Annual Minimum Data Set" (MDS) dated 09/07/20 documented R18 had a Brief Interview | F 554 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/03/2021

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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for Mental Status (BIMS) score of 15 which indicated intact cognition. R18 required extensive physical assistance with two staff with bed mobility and transfers; extensive physical assistance with one staff with dressing and personal hygiene. R18 received opioid (pain reducing medications) medications seven days of the seven-day lookback period.

The "Quarterly MDS" dated 04/09/21 documented R18 had a BIMS score of 15 which indicated intact cognition. R18 required extensive physical assistance with two staff with bed mobility and transfers; extensive physical assistance with one staff with dressing and personal hygiene. R18 received opioid medications seven days of the seven-day lookback period.

The "Activities of Daily Living (ADL)/Rehabilitation Potential Care Area Assessment" (CAA) dated 09/07/20 lacked an analysis of findings.

The "Discomfort Care Plan" dated 10/01/17 documented R18 had discomfort related to RA and old left shoulder injury and documented an intervention dated 03/25/19 that R18 received Voltaren (diclofenac- topical [the surface of a part of the body] gel used to treat pain) gel for pain management.

The "ADLS Care Plan" dated 10/01/17 documented R18 could not care for herself like she used to and she needed help to do daily cares and documented an intervention dated 01/17/20 that R18 received Refresh (eye drops used to treat dry eye symptoms) per orders.

The "Orders" tab of R18's EMR documented an order with an order date of 02/08/21 for Voltaren

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gel two grams transdermally (application of medication through the skin) four times a day for should and neck pain related to fibromyalgia and an order with a start date of 02/08/21 for Refresh Optive Advanced Solution one drop in both eyes every four hours as needed for dry eyes. The EMR lacked an order for self-administration of Voltaren and Refresh eye drops.

The "Assessments" tab of R18's EMR documented an "Initial Admission Record" assessment on 09/30/17, 01/14/19, 02/27/20, and 02/08/21 that documented R18 had no desire for self-administration of drugs.

The "Treatment Administration Record" documented R18 received Voltaren gel four times a day scheduled.

In an observation on 05/26/21 at 09:15 AM, Voltaren gel tube and Refresh eye drops bottle noted on R18's tray table.

In an observation on 05/27/21 at 09:11 AM, Voltaren gel tube and Refresh eye drops bottle noted on R18's tray table.

In an observation on 05/27/21 at 04:44 PM, Voltaren gel tube and Refresh eye drops bottle noted on R18's tray table.

In an observation on 06/01/21 at 01:56 PM, Voltaren gel tube on bathroom vanity and Refresh eye drops bottle on R18's tray table. R18 sat in her recliner and watched television, she appeared comfortable and without signs of distress.

In an interview on 05/27/21 at 09:11 AM, R18 stated it was difficult to put the Voltaren gel on

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| F 554 | Continued From page 3<br>herself and she did not think she had been assessed on whether she could have administered Voltaren gel and eye drops herself.<br><br>In an interview on 06/02/21 at 01:40 PM, Administrative Nurse D stated R18 did not have a self-administration of medication assessment in EMR.<br><br>In an interview on 06/02/21 at 02:02 PM, Licensed Nurse (LN) G stated residents could self-administer medications if there was a doctor's order to leave at bedside and the director of nursing approved it after a self-administration of medication assessment was completed.<br><br>In an interview on 06/02/21 at 02:41 PM, Administrative Nurse D stated residents could self-administer medications with a doctor's order. She stated a self-administration of medication assessment was completed by the interdisciplinary team (IDT) and care planned accordingly. She stated she was not aware of the Voltaren and Refresh eye drops in R18's room.<br><br>The facility did not provide a policy for self-administration of medications.<br><br>The facility failed to ensure self-administration of medications was safe and appropriate for R18. This had the risk for unnecessary medication side effects, in effective administration and self-administration errors. | F 554 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the | F 641 | | |

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| F 641 | Continued From page 4 | F 641 | | |

resident's status.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 61 residents. The sample included 19 residents. Based on observations, interviews, and record reviews, the facility failed to ensure accurate assessment and documentation on the Minimum Data Set (MDS) for race/ethnicity for R37 and documentation of anticoagulant (medication used to prevent blood from thickening or clotting) use for R44 and R48.

Findings included:
- The "Admission MDS" dated 03/24/21 documented R37's race/ethnicity as white.

The "Miscellaneous (Misc)" tab of R37's electronic medical record revealed a "History and Physical (H&P)" progress note by physician on 03/19/21. The H&P documented R37 was a "black gentleman."

An observation on 05/27/21 at 01:14 PM revealed R37 was a black man and sat in his wheelchair in his room. R37 did not appear to be in distress and was hopeful to be discharged from facility soon.

The "Admission MDS" dated 05/13/21 documented R44 received anticoagulant medications six days in the seven-day lookback period.

The "Orders" tab of R44's electronic medical record (EMR) documented an order with a start date of 05/08/21 for Plavix (antiplatelet-medication that prevented or inhibited platelets [component of blood involved in clotting] from adhering to each other and reduced the risk of

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blood clot formation) 75 milligrams (mg) in the morning for history of cerebrovascular accident (CVA [stroke] - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

The "Admission MDS" dated 05/10/21 documented R48 received anticoagulant medications six days in the seven-day lookback period.

The "Orders" tab of R48's electronic medical record (EMR) documented an order with start date of 05/21/21 for aspirin (medication that stopped the production of certain natural substances that caused fever, pain, swelling, and blood clots) 81 milligrams (mg) in the morning for clot prevention and an order with a start date of 05/21/21 for Plavix (antiplatelet- medication that prevented or inhibited platelets [component of blood involved in clotting] from adhering to each other and reduced the risk of blood clot formation) 75 milligrams (mg) in the morning for coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart).

In an interview on 06/02/21 at 01:18 PM, Administrative Nurse E stated admissions department documented the race/ethnicity in the MDS but she visited the residents after admission and reviewed the demographics. She stated aspirin and Plavix were not anticoagulant medications.

The facility's "Resident Assessment" policy, last revised 07/2018, directed the facility completed a comprehensive assessment of the resident's needs and the resident assessment was

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| F 641 | Continued From page 6<br>completed as directed by the state. The policy directed the nursing administration of the facility assured the completion of the resident assessment process enabled the development of an individualized comprehensive care plan for the resident.<br><br>The facility failed to ensure accurate assessment and documentation of race/ethnicity for R37 and anticoagulant medications for R44 and R48. This had the risk for misidentification/miscommunication with regards to resident care and care planning needs. | F 641 | | |