

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

PRINTED: 05/28/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175540	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2021
NAME OF PROVIDER OR SUPPLIER NOTTINGHAM HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 14200 W 134TH PLACE OLATHE, KS 66062		
(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 a Health Resurvey and Complaint Investigation KS00161870.	F 000			
F 550 SS=D	The 2567 was sent to the facility on 5/28/21 Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550			

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 550	Continued From page 1 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to promote care in a manner to maintain and enhance dignity and quality of life when staff placed Resident (R) 2, who was nonverbal and dependent on staff for activities of daily living (ADLs) at the dining table for extended periods of time prior to meals being served with no activity or interaction offered. Findings include: - The "Diagnoses Tab" in the electronic medical record (EMR) indicates R2 has diagnoses of Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), muscle weakness (condition of weak muscles) and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). The "Quarterly Minimum Data Set (MDS) Assessment" dated 02/17/21 indicated R2 required extensive assistance with ADLs including locomotion and eating. The MDS indicated that R2 had functional limitation on both	F 550			

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F 550	Continued From page 2 upper and lower sides of her body. The MDS recorded R2 was rarely or never able to express her ideas or wants. The "Annual MDS Assessment" dated 12/02/20 indicated R2 required extensive assistance with ADLs including locomotion and eating. The MDS indicated that R2 had functional limitation on both upper and lower sides of her body. R2 had severe cognitive impairment. The MDS recorded R2's family reported it was very important for R2 to be able to participate in her favorite activities and to listen to music. The "ADL Care Area Assessment (CAA)" was not triggered with the "Annual MDS" dated 12/20/20. The "ADL Comprehensive Care Plan" revised on 04/16/20 indicated that R2 required extensive assistance of one staff member for locomotion in the wheelchair and she requires encouragement and assistance with eating of one staff member. The "Activity Comprehensive Care Plan" revised on 10/06/20 indicated R2 enjoyed coloring and listening to music. The "Cognition Comprehensive Care Plan" revised on 12/11/20 indicated R2 would be provided with a homelike environment. The "Comprehensive Care Plan" revised on 04/16/21 lacked documentation for dining room preferences. Observation on 05/18/21 at 08:07 AM revealed staff wheeled Resident (R) 2 in a wheelchair from her room and placed at a dining table. R2's contracted hands laid her in lap. R2 remained at	F 550			

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F 550	Continued From page 3 the dining table without food or drink, interaction with staff or activity until at least 08:47 AM, when the observation ended. This was at least 40 minutes after being placed at the dining table. Observation on 05/19/21 at 11:13 AM revealed R2 sat in her wheelchair at a dining room table. R2 had bilateral contracted hands, placed in lap. No food or drink was provided. Staff walked by R2 several times but did not interact with her and did not provide her with an activity or music. At 11:30 AM, R2 continued to sit in wheelchair at the dining room table. Staff continued to walk by R2 and did not interact with her and did not provide her with any activity. Observation on 05/19/21 at 11:52 AM revealed R2 continued to sit in the wheelchair but now leaned to the right side of the wheelchair with her right elbow leaning on the armrest of the wheelchair. No food or drink was provided on the table. Staff did not interact with R2 and they did not provide her with an activity. Observation on 05/19/21 at 12:12 PM revealed R2 continued to sit in wheelchair and leaned to the right side, with no attention or interaction from staff. R2 was provided food and drink at 12:14 PM by staff, after being seated at the table with no interaction and/or activity for at least one hour. On 05/20/21 at 11:35AM, Certified Nurse Aide (CNA) P stated R2 requires assistance with eating. On 05/20/21 at 11:10AM, Licensed Nurse (G) stated R2 rarely feeds herself meals. She stated that staff had to feed her most of her meals. LN G was unaware of any specific preferences for	F 550			

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F 550	Continued From page 4 activity or dining for R2. On 05/20/21 at 02:55PM, Administrative Nurse D stated it may be some resident's preference to sit in a wheelchair in the dining room prior to meals being served, but she was uncertain if R2 had a documented preference to do so. She also stated that the information regarding preferences would be located in the care plan. The facility did not provide a policy regarding dining environment. The facility failed to provide a dining environment that promotes dignity and maintains or enhances quality of life for R2 when facility staff placed this dependant, nonverbal resident at the table before meals for more than 30 minutes with no interaction and did not offer her preferred activities. This placed her at risk for impaired dignity and decreased quality of life.	F 550			
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written	F 565			

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F 565	Continued From page 5 requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: The facility had a census of 35 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to resolve grievances recorded during resident council meetings. Findings included: - Review of the "Nottingham Health and Rehab Resident Council Survey September 2020," under the "Nursing" section recorded resident statement that "employees should have their name tags on." The "Nursing" response noted on the form indicated nursing department would be reeducated on wearing name tags. The "Nottingham Health and Rehabilitation	F 565			

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F 565	Continued From page 6 Resident Council Survey February 2021," under the "Nursing" section recorded residents stated that multiple employees were not wearing their name badges. The "Nursing "response noted the subject of employee badges would be discussed with nursing staff. The "Nottingham Health and Rehabilitation Resident Council Survey March 2021," under the "Nursing" section recorded residents stated multiple employees are "still not wearing their name badges." The "Nursing" response noted name tags has been discussed in" huddle." Review of the education log reviewed for September 2020 through May 2021 lacked evidence education was provided regarding the resident-expressed concern about staff failing to wear a name/employee badge. Observation on 05/18/21 at 07:18 AM revealed two unidentified female nursing staff on Holaday House with no name tag or name tape. Observation on 05/19/21 at 07:54 AM revealed unidentified female staff member in blue scrubs on Holaday House with no name/employee badge. A female staff member in black scrubs placed a piece of tape with her name on it on her scrub top. Observation on 05/19/21 at 07:58 AM revealed a female staff member seated at the nursing station with no name/employee badge. There was a piece of tape on the staff's scrub top however the name and title were not legible. Observation on 05/19/21 at 03:46 PM on Mercer House, an unidentified male staff member	F 565			

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F 565	Continued From page 7 wearing blue scrubs walked down the hall. He did not have a name/employee badge, or a name tape. Observation on 05/19/21 at 03:48 PM on Mercer House revealed an unidentified female staff in burgundy scrubs walked from the linen cabinet to room 105. She did not have a name/employee badge, or name tape. Observation on 05/19/21 at 03:51 PM revealed an unidentified female staff with purple scrubs wore a piece of tape on her scrub top but the name and title were difficult to read. On 05/18/21 at 08:36 AM R132 stated she wished staff would wear a name badge. She said she felt this would help her remember their name, if she could see it on their name badge. She also stated she would like to know if she was speaking to a nurse, or to a certified nurse assistant (CNA) when she was speaking with staff. She said some staff do wear a name badge, but most of the nursing staff did not. On 05/19/21 at 04:17 PM CNA N stated he received a name badge when he was hired. He said the badge was part of his uniform and he should be wearing it. He then removed the name badge from his pocket and attached it to his scrub top. On 05/19/21 at 04:19 PM CNA O stated she worked at the facility for "about a month." She further stated she was unsure if she needed to wear a name/employee badge as she had never received one. On 5/20/21 at 10:28 AM CNA M stated he was	F 565			

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F 565	Continued From page 8 issued a name tag upon hire and he verbalized it was considered part of the uniform. CNA M then pulled his name badge from his pocket, showed it to surveyor, and then placed back in his pocket. On 05/20/21 at 02:12 PM Activity Staff Z stated if issues are brought up in resident council, she sent the issues via email to the appropriate department. She said she would also include Administrative Staff A depending on the nature of the concern. Activity Staff Z reported the department leader would respond to her and let her know what the resolution was regarding the concern and then she would document that on the council minutes. Activity Staff Z stated that she was aware the residents had brought up the employee name badge concern on more than one occasion. She stated the machine was not working at one point in time, but it had been repaired and she thought staff had been issued a name badge. On 05/20/21 at 02:56 PM Administrative Nurse D stated Activity Staff Z sent out follow up emails from resident council. Administrative Nurse D said the concerns were then discussed at the daily clinical meeting or team call. She stated the issue had been discussed at Quality Assurance/ Performance Improvement (QAPI) at some point. She stated she did not even have a name badge. She had received one when she started last fall but had not been able to replace as the machine did not work consistently. She reported the facility was able to get it working for a short period of time so some staff did have a name badge She also reported if the staff had a badge, she expected them to wear it. Administrative Nurse D stated the huddles were informal education provided with the staff on duty. She also said if a	F 565			

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F 565	Continued From page 9 huddle was used as a grievance resolution or as documented education, it should be formally recorded and kept on record somewhere. The undated facility "Grievance/Concern Policy" recorded if a problem is not satisfactorily resolved, the Administrator will follow up with further investigation and will take appropriate action as indicated. The facility failed to respond to resident council grievances, placing the residents in the facility at risk for unresolved issues and a negative psychosocial outcome.	F 565			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 16 residents. Based on interviews, observations, and record reviews the facility failed to ensure the environment remained free of accident hazards as much as possible for three of six Residents (R), (R5, R182, and R20) sampled for accidents. Findings included: - The "Medical Diagnoses" tab of R5's electronic	F 689			

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F 689	Continued From page 10 medical record (EMR) documented diagnoses of muscle weakness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The "Admission Minimum Data Set" dated 03/15/20 documented a Brief Interview for Mental Status score of 15, which indicated intact cognition. She required supervision with her Activities of Daily Living (ADLs). R5 had sustained a bone fracture in the last six months prior to admission to the facility. She used a walker and a wheelchair for mobility in the facility. The "Falls Care Area Assessment" dated 03/15/20 documented R5 required staff assistance with her ADLs due to balance issues. She was encouraged to use her call light. The "Comprehensive Care Plan" dated 04/22/21 documented R5 was a high fall risk. The staff ensured her call light was within her reach. A "Progress Note" dated 03/25/21 documented R5 slipped and fallen in her bathroom. The staff reiterated the importance of using a call light to R5. A "Progress Note" dated 05/17/21 documented R5 had fallen in her room, when she had walked toward her door without a walker. On 05/19/21 at 08:15 AM R5 walked from her bathroom toward her recliner without a walker. The bathroom call light was placed on her	F 689			

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F 689	Continued From page 11 bedside table near the recliner. There was no call light in the bathroom. On 05/20/21 at 10:08 AM R5 sat in her recliner. The bathroom call light was on her bedside table. R5 stated she guessed she would yell if she had forgotten her call light and had fallen in the bathroom. There was no call light in the bathroom. On 05/20/21 at 10:27 AM Certified Nurse Aide M stated R5's bathroom call light was given to her and she took it with her when she walked to the bathroom. On 05/20/21 at 10:54 AM Licensed Nurse G stated R5's room call light cord did not reach her recliner and the staff placed the bathroom light within her reach. R5 was to carry the light with her when she went to the bathroom. Interview on 05/20/21 at 02:56 PM Administrative Nurse D stated the call light boxes were meant to be taken off and used as mobile call lights. She said the residents could remove it, or staff could, if they decided it was appropriate. Administrative Nurse D stated using the bathroom call light boxes as mobile units allowed the residents to use them in all areas of the facility and outside if desired. Administrative Nurse D said if there was ever an issue where the resident's bathroom would require the call light box while it being used as a mobile unit outside the bathroom, the facility kept extra call light boxes located in the maintenance closet, which staff were able to access. The facility's untitled, undated policy regarding falls recorded "Each patient residing at this facility	F 689			

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F 689	Continued From page 12 is provided services and care that ensures that the patient's environment remains as free from accident hazards as possible and that injuries are minimized." It further documented direct care staff would observe for, and report, environmental conditions that could increase a "patient's" risk for falls. The facility failed ensure an environment free of risks and hazards when they failed to provide a bathroom call light for R5, who had a prior fall in the bathroom. This placed R5 at risk for injuries due to accidents. - R182's electronic medical record (EMR) from the "Diagnoses" tab documented diagnoses of diabetes mellitus (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), atrial fibrillation (rapid, irregular heart beat), and hypertension (elevated blood pressure). The "Admission Minimum Data Set" (MDS) was not yet completed for R182. R182's "Baseline Care Plan" dated 05/04/21 documented, under the "Safety" section, R182 required nonskid foot wear. Staff were to assist her with activities of daily living (ADL) if	F 689			

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F 689	Continued From page 13 requested. Staff were to encourage her to use the call light. The "Baseline Care Plan" lacked mention of an intervention placed after her fall on 05/07/21. A "Fall Note" in R182's EMR recorded a nurse found R182 on the floor at the foot of R182's bed. R182 stated she was attempting to get her stuffed bear that fell on the floor. R182 was noted to have a skin tear on her left upper extremity. Review of R182's May 2021 "Treatment Administration Record" (TAR) revealed an order dated 05/08/21 for fall follow up for three days. The order directed staff to document adverse reaction in progress note. The order also recorded " Intervention: Ensure stuffed bear is within reach while in bed two times a day for Fall Follow up for 3 Days..." The TAR was signed off by nursing staff on both day and night shift from 05/08/21 through 05/10/21. The order was then auto-stopped. R182's clinical records and EMR lacked evidence a different intervention was implemented for the fall on 05/07/21. Observation on 05/19/21 at 11:13 AM R182 laid in bed, positioned on her left side. Her stuffed bear sat on the top of her dresser, across the room. Observation on 05/20/21 at 10:16 AM R182 laid in bed, with the head of bed elevated slightly. She was positioned on her left side. R182's stuffed bear was on the dresser across the room. On 05/20/21 at 10:28 AM during an interview, Certified Nurses Aide (CNA) M stated R182's fall interventions was to have her call light in reach	F 689			

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F 689	Continued From page 14 and bed in lowest position. On 05/20/21 at 11:10 AM during an interview, Licensed Nurse (LN) G stated that after each fall and/or incident, an order was placed on the TAR, which documented the intervention that was put in place for the fall and/or incident. LN G said the care plan was updated with the interventions put in place. On 05/20/21 at 03:00 PM during an interview, Administrative Nurse D stated that the nurse completed an assessment on every fall, an intervention was placed on the TAR, along with the three day follow up charting. The intervention was placed onto the care plan and she also stated that the staff was notified of the new intervention from group meeting (huddles), email (for the staff who had email) and the care plan. The facility's untitled, undated policy regarding falls recorded "Each patient residing at this facility is provided services and care that ensures that the patient's environment remains as free from accident hazards as possible and that injuries are minimized." It further documented direct care staff would observe for, and report, environmental conditions that could increase a "patient's" risk for falls. The facility failed to implement the fall intervention for R182 past three days, or replace with an updated intervention, which placed her at risk for injury from future falls.	F 689			

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F 689	Continued From page 15 - The "Medical Diagnoses" tab of R20's electronic medical record (EMR) documented diagnoses of hypertension (elevated blood pressure), and diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin). The "Quarterly Minimum Data Set" (MDS) dated 01/14/21 documented R20 required extensive assistance of two staff for toileting and extensive assistance of one staff for transfers. The "Significant Change MDS" dated 04/16/21 documented a Brief Interview for Mental Status score of 13, which indicated intact cognition. She required extensive assistance of one person for toileting and extensive assistance of two staff for transfers. The "Fall Care Area Assessment" dated 04/29/21 documented R20 had balance problems and required assistance with ADLs. She had sustained recent falls and the current plan of care was continued. The CAA recorded she would wear nonskid footwear and would receive assistance with ADLs as required. The "Care Plan", located in R20's EMR under the "Care Plan" tab, for ADL/Mobility Focus with a Last Care Plan Review Completed date of 05/18/21 recorded an intervention revised on 02/01/21 which directed R20 required extensive assistance of two staff members for toileting. Another intervention, revised on 02/01/21, directed R20 required extensive assistance of two staff for transfers. She was encouraged to use her call light for transfer assistance. The "Care Plan" for Falls Focus with a Last Care	F 689			

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F 689	Continued From page 16 Plan Review Completed date of 05/18/21 recorded an intervention initiated on 01/30/21 and revised on 02/01/21 directed R20 required "2 staff for all transfers" A scanned image of the "Care Plan," provided via email on 05/20/21 recorded a Last Care Plan Review Completed date of 03/03/21. The Falls Focus documented a typed intervention with the date cut off of "2 staff for all transfers." The intervention had a "1-" handwritten before the typed intervention and the handwritten change was not dated or initialed. This image also listed a handwritten intervention, dated 04/04/21 which noted "NIF [non injury fall] Intervention:Non-skid socks/footwear with transfers as resident allows." This same scanned image listed a typed intervention which directed "TOILETING ext assist of 2 staff." The "2" was crossed out and "1-2" was added in handwriting and dated 03/11/21 and initialed by Administrative Nurse D. A "Nursing Progress Note" dated 01/30/21 documented R20 fell in her bathroom when her knees buckled underneath her. One staff member was present during fall. Per facility "Fall Investigation" documentation dated 01/31/21, the intervention put in place after the fall on 01/30/21 directed two staff members would assist with transfers. A "Nursing Progress Note" dated 04/05/21 documented on 04/04/21 at 10:56 PM R20 was being assisted with transfer to the toilet by one staff member. R20's legs became weak and she was lowered to the floor. On 05/20/21 at 11:35 AM Certified Nurse Aide	F 689			

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F 689	Continued From page 17 (CNA) P revealed that there is a Kardex (tool used to inform staff of resident specific cares) which lets her know what kind of assistance R20 needed with ADLs. She stated R20 needed assist of one, sometimes two staff members with transfers. On 05/20/21 at 11:10 AM Licensed Nurse (LN) G stated that fall interventions are immediately placed on the "Treatment Administration Record" (TAR) and care plan after a fall. She also stated she is only aware of the care plan found on the EMR. She also stated that she was not aware R20 required two staff members per her care plan, for all transfers. She stated that she requires one to two staff members. On 05/20/21 at 02:56 PM Administrative Nurse D stated that fall interventions are immediately placed on the TAR for documentation for three days and then put on the care plan in the care plan book. Administrative Nurse D also stated that the care plan located in the EMR drives the Point of Care (POC) software for the CNAs to know what the interventions are in place for a fall. The facility's untitled, undated policy regarding falls recorded "Each patient residing at this facility is provided services and care that ensures that the patient's environment remains as free from accident hazards as possible and that injuries are minimized." It further documented direct care staff would observe for, and report, environmental conditions that could increase a "patient's" risk for falls. The facility failed to use two members to toilet R20 as required in her plan of care. This placed R20 at increased risk injuries related to falls.	F 689			

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756			

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F 756	Continued From page 19 This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 16 residents with five residents reviewed for medications. Based on observation, record review and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported the facility's failure to administer medications to Resident (R) 20 following the physician order. Findings Include: - The "Medical Diagnoses" tab of R20's electronic medical record (EMR) documented diagnoses of hypertension (elevated blood pressure), and diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin). The "Significant Change Minimum Data Set" dated 04/16/21 documented a Brief Interview for Mental Status score of 13, which indicated intact cognition. She required extensive staff assistance with her activities of daily living. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 04/29/21 documented R20 required a significant change assessment related to a decline in ADLs and admission to hospice services. The "Comprehensive Care Plan" initiated on 11/15/2019 documented to administer medications as ordered. The "Physician's Order Sheet" revealed an order for Lisinopril-Hydrochlorothiazide	F 756			

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F 756	Continued From page 20 (antihypertensive-to reduce blood pressure; diuretic-to reduce extra fluid in the body) medication. The order indicated Lisinopril-Hydrochlorothiazide tablet 20-25mg table to be given by mouth every morning and to hold the medication if blood pressure was less than 140 systolic millimeter of mercury (mmHg) and 90 diastolic mmHg (140/90mmHg), on 12/31/20. Review of the Medication Administration Record (MAR)from February 2021 through May 2021 revealed the following: February-Eleven days were documented medication given with blood pressure lower than 140/90mmHg March- 14 days were documented medication given with blood pressure lower than 140/90mmHg. April- Two days were documented medication given with blood pressure lower than 140/90mmHg. May- Two days were documented medication given with blood pressure lower than 140/90mmHg. Review of the EMR from February 2021 through May 2021 lacked documentation indicating the Lisinopril-Hydrochlorothiazide was held as instructed per order . Review of the CP's "Monthly Medication Regimen Review" from May 2020 through May 2021 lacked documentation for the need to hold medications when outside physician order parameters. Observation on 05/19/21 at 02:06PM revealed R20 in a wheelchair sitting in the dining room watching a movie with the other residents.	F 756			

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F 756	Continued From page 21 On 05/21/21 at 01:47PM Licensed Nurse (LN) G stated that medications that are to be held are entered as "no" not given and a prompt is given to indicate why it was not given. On 05/24/21 at 09:18AM Consultant GG stated she does review the EMR for every resident in the facility monthly. She said she does not review every medication for R20 every month, and she only checks the medication administration randomly. On 05/21/21 at 02:56PM Administrative Nurse D stated a medication given outside of the hold parameter would be a medication error and she would have to investigate that. The facility's "Administering Medication" Policy revised on 05/01/2019 instructed that medication must be administered in accordance with the orders, including time frame. The facility failed to ensure the CP identified and reported the facility's failure to administer medications to R20 following the order parameters. This put R20 at risk for medical complications such as low blood pressure and dehydration.	F 756			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757			

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F 757	Continued From page 22 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 16 residents with five residents reviewed for medications. Based on observation, record review and interview, the facility failed failure to administer medications to Resident (R) 20 following the physician order. Findings Include: - The "Medical Diagnoses" tab of R20's electronic medical record (EMR) documented diagnoses of hypertension (elevated blood pressure), and diabetes mellitus (when the body cannot use glucose, not enough insulin is made or the body cannot respond to the insulin). The "Significant Change Minimum Data Set" dated 04/16/21 documented a Brief Interview for Mental Status score of 13, which indicated intact cognition. She required extensive staff assistance with her activities of daily living.	F 757			

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F 757	Continued From page 23 The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 04/29/21 documented R20 required a significant change assessment related to a decline in ADLs and admission to hospice services. The "Comprehensive Care Plan" initiated on 11/15/2019 documented to administer medications as ordered. The "Physician's Order Sheet" revealed an order for Lisinopril-Hydrochlorothiazide (antihypertensive-to reduce blood pressure; diuretic-to reduce extra fluid in the body) medication. The order indicated Lisinopril-Hydrochlorothiazide tablet 20-25mg table to be given by mouth every morning and to hold the medication if blood pressure was less than 140 systolic millimeter of mercury (mmHg) and 90 diastolic mmHg (140/90mmHg), on 12/31/20. Review of the Medication Administration Record (MAR)from February 2021 through May 2021 revealed the following: February-Eleven days were documented medication given with blood pressure lower than 140/90mmHg March- 14 days were documented medication given with blood pressure lower than 140/90mmHg. April- Two days were documented medication given with blood pressure lower than 140/90mmHg. May- Two days were documented medication given with blood pressure lower than 140/90mmHg.	F 757			

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F 757	Continued From page 24 Review of the EMR from February 2021 through May 2021 lacked documentation indicating the Lisinopril-Hydrochlorothiazide was held as instructed per order . Observation on 05/19/21 at 02:06PM revealed R20 in a wheelchair sitting in the dining room watching a movie with the other residents. On 05/21/21 at 01:47PM Licensed Nurse (LN) G stated that medications that are to be held are entered as "no" not given and a prompt is given to indicate why it was not given. On 05/21/21 at 02:56PM Administrative Nurse D stated a medication given outside of the hold parameter would be a medication error and she would have to investigate that. The facility's "Administering Medication" Policy revised on 05/01/2019 instructed that medication must be administered in accordance with the orders, including time frame. The facility failed to administer medications to R20 following the physician order parameters. This put R20 at risk for medical complications such as low blood pressure and dehydration.	F 757			
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents.	F 760			

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NAME OF PROVIDER OR SUPPLIER NOTTINGHAM HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 14200 W 134TH PLACE OLATHE, KS 66062		
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F 760	Continued From page 25 The sample included 16 residents with five residents reviewed for medications. Based on observation, interview, and record review, the facility failed to administer intravenous (IV-given in the vein) antibiotic medication to Resident (R) 24 for the correct number of doses as ordered by the physician. This put R24 at risk for unwarranted side effects, complications or prolonged infection. Findings Include: -The "Medical Diagnoses" Tab of R24's electronic medical record (EMR) documented diagnoses of diabetes mellitus type two (condition of too much sugar in the blood), urinary tract infection (an infection of the urinary system) and urinary retention (the retention of urine in the bladder). The "Admission Minimum Data Set (MDS) Assessment" dated 04/22/21 indicated that R24 requires extensive assistance of one to two staff members with her Activity of Daily Living (ADL)s. The MDS indicated she scored a 15 on her Brief Interview for Mental Status (BIMS), which indicated intact cognition. The "Activity of Daily Living Function/Rehabilitation Potential Care Area Assessment (CAA)" dated 04/30/21 documented R24 required assistance with ADL's as indicated and would be working with therapy. The "Comprehensive Care Plan" initiated on 05/11/21 directed staff to administer medications as ordered. The "Physician's Order Sheet" revealed an order dated 04/04/21 for Meropenem (antibiotic for	F 760			

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F 760	Continued From page 26 treating bacterial infection) solution reconstituted 500 milligrams (mg). The order was to administer 500 mg intravenously every six hours for urinary tract infection (UTI) until 04/10/2021 at 11:59. It documented a start Date 04/04/2021 at 12:01 AM.. Review of the "Medication Administration Record (MAR)" for April 2021 revealed the Meropenem 500MG, lacked documentation of administration for seven out of 28 doses. Review of the "Progress Notes" in April 2021, lacked documentation of why Meropenem 500MG was not given and lacked documentation the physician was notified. On 05/20/21 at 01:51 PM R24 stated she was not aware if she missed doses of her IV medication. On 05/20/21 at 01:05PM Licensed Nurse (LN) I stated that when an IV medication is not given it would be noted as not given by answering a "no" to the question in the MAR. She stated once answered as a no, then a progress note would need to be completed explaining why the medication was not given. She also stated that there is an alert on the MAR that indicated when a medication is not given. On 05/20/21 at 01:47PM LN G stated that when an IV medication is held or not given, a "no" is selected on the MAR and a progress note is needed to confirm why a medication is not given. She stated that if there was lack of documentation on a medication, it may not have been given. On 05/20/21 at 02:56PM Administrative Nurse D	F 760			

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F 760	Continued From page 27 stated that if the MAR lacked a signature indicating administration was completed, she would need to investigate it. She was unaware of any concerns with R24's medication administration. The facility's "Administering Medication" Policy Revised 05/2019 states that medication must be administered in accordance with the orders, including required time frame. The facility failed to ensure staff administered IV Meropenem 500MG to R24 as ordered by the physician, which placed R24 at risk for unwarranted side effects, complications and prolonged illness.	F 760			
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761			

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F 761	Continued From page 28 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. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents, two medication carts, two treatment carts, and two medication rooms. Based on observations, record reviews, and interviews, the facility failed to ensure medication carts and medication rooms were free of expired medications; failed to properly label and store three opened insulin (medication used to treat a chronic condition that affected the way the body processed blood sugar) pens, medicated eye drops, one medication inhaler (device used for administering a medication that was breathed in to relieve asthma or other lung disorders), and two topical (application or action on the surface of a part of the body) patches/powders; failed to properly store medications; failed to ensure two influenza vaccine vials were discarded after expiration date; and failed to ensure one insulin pen was discarded after expiration date. Findings included: - On 05/18/21 at 07:30 AM the 200-hall medication room contained the following expired medications: Ztildo 1.8 percent patch (topical analgesic used to treat pain) 12 patches which expired February 2021 On 05/18/21 at 07:27 AM, the 200-hall medication cart contained the following medications that	F 761			

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F 761	Continued From page 29 were expired, topical powder that was not labeled properly, and medication not stored or labeled properly: Vitamin C tablet bottle, expired October 2020 Aspirin (Nonsteroidal Anti-inflammatory Drug [NSAID]- medication used to treat pain, fever, and inflammation) 325 milligram tablet bottle, expired January 2021 Neuriva (brain performance supplements) capsule bottle, expired January 2021 Sodium Bicarbonate (antacid- medication used to treat heartburn, indigestion, and upset stomach) tablet bottle, expired January 2020 Nystatin (antifungal medication) powder bottle- opened but no resident name on bottle Five unidentified white, round tablets in a clear pill-crush packet On 05/18/21 at 07:44 AM, the 100-hall treatment cart contained the following insulin pens and topical ointment: One Levemir insulin pen observed on top of treatment cart, no open date One Novolog insulin pen observed on top of treatment cart, no open date One Basaglar insulin pen, no name or open date One Humalog insulin pen, opened 04/15/21 On 05/18/21 at 07:52 AM, the 100-hall medication cart contained the following medicated eye drops, medicated inhaler, nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) medications, and medications that were expired: Two bottles of Lantanoprost eye drops (medication used to lower pressure in the eye by increasing the flow of natural eye fluids out of the eye) opened, no open date	F 761			

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F 761	Continued From page 30 One inhaler of Stiolto Respimat (medication used to control and prevent symptoms caused by ongoing lung disease) opened, no open date One foil packet of budesonide (medication used to control and prevent symptoms caused by asthma) nebulizer treatment vials opened, no open date Bisacodyl (laxative) tablet bottle, expired February 2020 Rena-vite (multivitamin) tablet bottle, expired May 2020 Vitamin D3 tablet bottle, expired May 2020 Sodium Bicarbonate tablet bottle, expired March 2021 Geri-Lanta (antacid) bottle, expired February 2021 On 05/18/21 at 08:25 AM, 100-hall medication room contained the following expired medications: Prostat (liquid formulated to provide 15 grams of protein for wounds or malnutrition) bottle, expired 03/18/21 Two influenza vaccination vials in refrigerator, expired 06/30/20 A review of the manufacturer's instructions for Levemir insulin pens directed Levemir pens stored at room temperature should be discarded after 42 days. A review of the manufacturer's instructions for Humalog insulin pens and multi-use vials directed Humalog pens and vials stored at room temperature should be discarded after 28 days. A review of the manufacturer's instructions for Basaglar insulin pens directed Basaglar pens stored at room temperature should be discarded after 28 days.	F 761			

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F 761	Continued From page 31 A review of the manufacturer's instructions for Novolog insulin pens directed Novolog pens stored at room temperature should be discarded after 28 days. A review of the manufacturer's instructions for Lantanoprost eye drops directed Lantanoprost eye drops stored at room temperature should be discarded after six weeks. A review of the manufacturer's instructions for budesonide nebulizer vials directed budesonide nebulizer vials stored in an opened foil package should be discarded after two weeks. A review of the manufacturer's instructions for Stiolto Respimat inhaler directed Stiolto Respimat inhalers, once assembled, should be discarded after three months. On 05/18/21 at 07:30 AM Certified Medication Aid (CMA) R stated Administrative Nurse D was responsible for the disposition of all expired and unused medications. She stated if she identified any medications that were expired, she would take them immediately to Administrative Nurse D. On 05/20/21 at 02:56 PM Administrative Nurse D stated the facility had a system for checking for expired medications. She stated she was surprised to hear there were expired medication since she and a few others had spent a day the previous week cleaning out the medication rooms. Administrative Nurse D stated the task of checking for expired medications was assigned to whoever was on duty, primarily night shift. She also reported that recently, the consulting pharmacist had started making onsite visits again	F 761			

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F 761	Continued From page 32 and would be assisting in medication disposition. The facility policy "Storage of Medications" dated 08/01/19 documented drugs and biologicals would be stored in the package, container or dispensing system in which they were received and only the issuing pharmacy was authorized to transfer medications between containers. It further recorded the facility would not use discontinued, outdated or deteriorated drugs or biologicals. All such drugs would be returned to the pharmacy or destroyed. The facility failed to ensure medications were stored, labeled and dated properly, and failed to ensure expired and outdated medications were disposed of properly. This placed residents at risk for decreased or ineffective therapeutic treatments and increased risk for complications related to illness treated by the affected medications.			F 761			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			F 880			

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F 880	Continued From page 33 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880			

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F 880	Continued From page 34 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. Based on observation, record review and interviews the facility failed to ensure staff practiced standard infection control practices regarding appropriate hand hygiene in order to prevent the spread of infection. This had the potential to increase the residents' risk for transmission of infectious disease. Findings included: - Observation on 05/19/21 at 11:18 AM Licensed Nurse (LN) H washed her hands with soap and water, donned gloves, detached the tabs from the right side of R182's incontinent brief, removed a soiled dressing from the coccyx pressure wound (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), and tossed the soiled dressing into the trash can. She then doffed her gloves and donned a clean pair of gloves but did not sanitize hands between dirty and clean gloves. LN H then cleansed the wound bed, doffed gloves and donned a new pair of gloves, again without hand sanitizing. LN H cut a strip of	F 880			

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F 880	Continued From page 35 calcium alginate (a dressing used to soak up loose debris from a wound and provide an optimal environment for healing), placed it in the wound, covered the wound with a new foam dressing. LN H doffed her gloves, washed her hands with soap and water donned a new pair of gloves, removed a soiled dressing from a pressure wound on R182's left heel, doffed her gloves, and immediately donned a new pair of gloves without performing hand hygiene. She sprayed wound cleaner on to the wound, doffed gloves and donned a new pair of gloves, again without performing hand sanitization. She dried the wound area with a gauze pad, applied skin prep (a solution when applied that forms a protective waterproof barrier on the skin) to the perimeter of wound and triple antibiotic ointment (topical antibiotic used to prevent minor skin injuries from becoming infected). She then doffed gloves and without hand sanitizing, donned a new pair of gloves, and applied a foam dressing. LN H pulled the bedding over R182's lower extremities, doffed her gloves, raised the head of R182's bed, and adjusted the pillows before she washed her hands with soap and water. Observation on 05/19/21 at 12:00 PM Consultant HH entered the Mercer household wearing a pair of blue surgical gloves. He stopped and talked with two unidentified residents at one table, he shook their hands, touched their shoulders, and then he moved to another table where he was observed examining a different unidentified resident's right eye. Consultant HH touched the residents face and around her right eye. Consulted HH then exited the unit without removing his gloves or washing his hands. On 05/20/21 at 11:35 AM Certified Nurse Aid	F 880			

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F 880	Continued From page 36 (CNA) P stated had received hand hygiene training. She said facility nurse managers do review hand hygiene with staff. CNA P stated she washed hands with soap and water anytime she felt her hands were dirty or visibly soiled, otherwise she used hand sanitizer. On 05/20/21 at 03:00 PM Administrative Nurse D stated during an interview that she expected the staff to wash their hands when visibly soiled otherwise the staff could use hand sanitizer. Administrative Nurse D stated nursing staff should perform hand hygiene between donning and doffing gloves when care was given. She stated multiple trainings and education had been provided to all staff regarding hand hygiene and infection control. The "Handwashing/Hand Hygiene" facility policy dated 05/01/19 documented all personnel shall be trained and regularly in-serviced on the importance of hand hygiene to prevent the transmission n of healthcare associated infections. The policy also documented that the use of gloves did not replace handwashing or hand hygiene. The facility failed to ensure staff practiced standard infection control precautions in order to prevent the spread of infection when staff failed to perform proper hand hygiene. This had the potential to increase the risk for transmission of infectious disease to residents.	F 880			