STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175472	A. BUILDING _____ B. WING _____	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSIDE VILLAGE OF DE SOTO	33600 WEST 85TH STREET DE SOTO, KS 66018

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This Requirement is not met as evidenced by: The facility identified a census of 42 residents. The sample included one resident reviewed for hospice services. Based on observation, interview and record review the facility failed to provide a physician ordered breathing treatment for resident #33. Findings included: - Review of the electronic medical record (EMR) revealed resident #33 had a diagnosis of chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The annual Minimum Data Set (MDS) dated 09/28/18 recorded a Brief Interview for Mental Status (BIMS) of 14 indicating intact cognition. Resident received oxygen therapy while a resident. Resident #33 required extensive assistance with 2 staff members for activities of daily living (ADLs).	F 684		

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 684	Continued From page 1 The care area assessment for activities of daily living revealed resident #33 requires staff assistance with activities of daily living due to muscle weakness, impaired balance and coordination. Review of the EMR revealed resident #33 had a physician's order dated 05/21/18 instructing staff to check oxygen saturation every shift. If oxygen saturation is 90 percent or less give an as needed (PRN) DuoNeb treatment (bronchodilator that relax muscles in the airways and increase air flow to the lungs). The electronic medical record lacked evidence that nursing staff administered the PRN DuoNeb treatment for an oxygen saturation of less than 90 percent on the following dates in July on evening shift: July 3rd, 4th, 6th, and 8th. In June, on the evening shift, DuoNeb treatment was not administered per physician order on the following dates: June 1st, 6th, 8th, 9th, 11th, 12th, 24th and 25th. During an interview on 07/25/19 at 10:18 AM, Administrative Nurse D stated if there was a blank in the medication administration record (MAR) or treatment administration record (TAR) it indicated the medication wasn't given and/or the treatment wasn't done. The facility policy dated September 2017 stated all medications will be administered as ordered by a health care professional authorized by the state to order medications. The facility failed to follow physician orders for resident #33's PRN DuoNeb treatment order resulting in a potential decline for his/her physical well-being.	F 684		

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F 756 SS=D	Continued From page 2 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	F 756		

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F 756	Continued From page 3	F 756		

requires urgent action to protect the resident. This Requirement is not met as evidenced by: The facility identified a census of 42 residents. The sample included 18 residents of which five residents were reviewed for unnecessary medications. Based on record review, observation and interviews, the facility failed to ensure the consulting pharmacist identified irregularities related to medication given 10 times out of parameters ordered by the physician for Resident #19.

Findings include:

- The electronic medical record (EMR) documented diagnosis of hypertension (elevated blood pressure).

The annual minimal data set (MDS) dated 08/04/18 documented a Brief Interview for Mental Status (BIMS) score of 09 which indicated moderately impaired cognition. Resident #19 required extensive assistance of one staff person for Activities of Daily Living (ADLs). The MDS documented the diagnosis of hypertension.

The quarterly MDS dated 5/7/19 documented a BIMS of 05 which indicated severely impaired cognition. Resident 19 required extensive assistance of one staff person for ADLs. The MDS documented the diagnosis of hypertension.

The Care Area Assessment (CAA) for ADLs dated 08/05/18 documented the resident required minimal assistance with ADLs related to dementia (progressive mental disorder characterized by failing memory, confusion)

The care plan dated 08/10/18 documented resident #19 took losartan (angiotensin receptor

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F 756	Continued From page 4	F 756		

blocker) for hypertension. It directed staff to observe for side effects such as dizziness, fatigue, headache, low blood pressure (BP), and orthostatic hypotension (blood pressure dropping with change of position).

The EMR revealed an order dated 03/25/19 for losartan potassium tablet 100 mg (milligram) one tablet by mouth in the morning for hypertension hold for systolic blood pressure (SBP-minimum level of blood pressure measured between contractions of the heart; the top number of a blood pressure reading) less than or equal to 120 millimeters of mercury (mmHg).

The EMR documented that losartan was given outside the parameters 10 times as ordered by the physician 01/06/19- 119/82 mmHg; 12/14/18-120/78 mmHg; 12/31/18-120/65 mmHg; 11/6/18-120/80 mmHg; 11/14/18 119/80 mmHg; 11/27/18-120/78 mmHg; 10/01/18-118/76 mmHg; 10/04/18-113/84 mmHg; 09/09/18-118/74 mmHg; 09/17/18-115/89 mmHg. The nurses note lacked documentation that the physician was notified.

The EMR revealed an order dated 07/23/18 for clonidine 0.1 mg(milligram) one tablet by mouth bid (twice a day) as needed (PRN) for hypertension if SBP is greater than 160 mmHg.

The EMR documented that clonidine was not given 19 times as ordered by the physician when the SBP was greater than 160 mmHg on 11/01/18-174/75 mmHg; 11/03/18-196/9 3mmHg; 11/07/18-190/94 mmHg; 11/08/18- 186/92 mmHg; 11/10/18-168/93 mmHg; 11/12/18-165/81 mmHg; 11/18/18-168/51 mmHg; 11/19/18-183/91 mmHg; 11/20/18-180/89 mmHg; 11/21/18-164/80 mmHg; 11/23/18-179/92 mmHg; 11/18/18-167/94 mmHg; 10/13/18-163/89 mmHg; 10/2018-184/87 mmHg;

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F 756	Continued From page 5	F 756		

10/22/18-162/78 mmHg; 10/30/18-162/92 mmHg; 08/09/18-176/85 mmHg; 08/14/18-169/90 mmHg; 08/27/18-166/84 mmHg. The nurses note lacked documentation that the physician was notified.

An observation on 07/24/19 at 09:33 AM Resident #19 was walking independently with walker in hallway

During an interview with staff member R on 07/25/19 at 09:10 AM stated that parameters to follow for the medication ordered by the physician are listed on medication administration record (MAR) and the certified medication aide will hold the medication and notify the nurse in charge.

During an interview with licensed nurse G on 07/25/19 at 09:28 AM stated that the parameters for the medication order are listed in medication administration record (MAR). The CMA notifies the nurse and charge and then the physician is notified by phone or by communication sheet.

During an interview on 07/25/19 at 10:18 AM with administration licensed nursing staff D stated that the parameters are listed on the MAR with the medication orders. The physician is notified via phone or communication sheet during the week.

During interview with consulting pharmacist GG on 07/30/19 at 12:50 PM stated that he/she notifies the director of nursing by email monthly of any irregularities. Staff GG stated that he/she reviews the parameters ordered by the physician, MAR and vital signs monthly, she only notifies the facility if a vital sign is egregiously out of the parameter set by the physician if right on the parameter then he/she does not notify the facility.

The facility Medication Monitoring policy dated

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F 756	Continued From page 6 11/17 documented that the consulting pharmacist will review each residents medication regimen at least monthly. The facility failed to ensure that the consulting pharmacist noted the irregularities related to medication given and/or not given per physician ordered parameters for Resident #19 to prevent a potential adverse outcome.	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 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 42 residents. The sample included 18 residents of which five residents were reviewed for unnecessary medications. Based on record review, observation and interviews, the facility failed to	F 757		

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F 757	Continued From page 7	F 757		

administer medication within physician ordered parameters for Resident #19.

Findings include:

- The electronic medical record (EMR) documented diagnosis of hypertension (elevated blood pressure).

The annual minimal data set (MDS) dated 08/04/18 documented a Brief Interview for Mental Status (BIMS) score of 09 which indicated moderately impaired cognition. Resident #19 required extensive assistance of one staff person for Activities of Daily Living (ADLs). The MDS documented the diagnosis of hypertension.

The quarterly MDS dated 5/7/19 documented a BIMS of 05 which indicated severely impaired cognition. Resident 19 required extensive assistance of one staff person for ADLs. The MDS documented the diagnosis of hypertension.

The Care Area Assessment (CAA) for ADLs dated 08/05/18 documented the resident required minimal assistance with ADLs related to dementia (progressive mental disorder characterized by failing memory, confusion)

The care plan dated 08/10/18 documented resident #19 took losartan (angiotensin receptor blocker) for hypertension. It directed staff to observe for side effects such as dizziness, fatigue, headache, low blood pressure (BP), and orthostatic hypotension (blood pressure dropping with change of position).

The EMR revealed an order dated 03/25/19 for losartan potassium tablet 100 mg (milligram) one tablet by mouth in the morning for hypertension

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hold for systolic blood pressure (SBP-minimum level of blood pressure measured between contractions of the heart; the top number of a blood pressure reading) less than or equal to 120 millimeters of mercury (mmHg).

The EMR documented that losartan was given outside the parameters 10 times as ordered by the physician 01/06/19- 119/82 mmHg; 12/14/18-120/78 mmHg; 12/31/18-120/65 mmHg; 11/6/18-120/80 mmHg; 11/14/18 119/80 mmHg; 11/27/18-120/78 mmHg; 10/01/18-118/76 mmHg; 10/04/18-113/84 mmHg; 09/09/18-118/74 mmHg; 09/17/18-115/89 mmHg. The nurses note lacked documentation that the physician was notified.

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The EMR documented that clonidine was not given 19 times as ordered by the physician when the SBP was greater than 160 mmHg on 11/01/18-174/75 mmHg; 11/03/18-196/9 3 mmHg; 11/07/18-190/94 mmHg; 11/08/18- 186/92 mmHg; 11/10/18-168/93 mmHg; 11/12/18-165/81 mmHg; 11/18/18-168/51 mmHg; 11/19/18-183/91 mmHg; 11/20/18-180/89 mmHg; 11/21/18-164/80 mmHg; 11/23/18-179/92 mmHg; 11/18/18-167/94 mmHg; 10/13/18-163/89 mmHg; 10/2018-184/87 mmHg; 10/22/18-162/78 mmHg; 10/30/18-162/92 mmHg; 08/09/18-176/85 mmHg; 08/14/18-169/90 mmHg; 08/27/18-166/84 mmHg. The nurses note lacked documentation that the physician was notified.

An observation on 07/24/19 at 09:33 AM Resident 19 was walking independently with walker in hallway

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F 757	Continued From page 9 During an interview with staff member R on 07/25/19 at 09:10 AM stated that parameters to follow for the medication ordered by the physician are listed on medication administration record (MAR) and the certified medication aide will hold the medication and notify the nurse in charge. During an interview with licensed nurse G on 07/25/19 at 09:28 AM stated that the parameters for the medication order are listed in medication administration record (MAR). The CMA notifies the nurse and charge and then the physician is notified by phone or by communication sheet. During an interview on 07/25/19 at 10:18 AM with administration licensed nursing staff D stated that the parameters are listed on the MAR with the medication orders. The physician is notified via phone or communication sheet during the week. The facility Medication Monitoring policy dated 11/17 documented that parameters will be maintained in the resident's clinical record and if any outside the parameters of normal for the resident the licensed nurse will report symptoms the physician. The facility failed to ensure that Resident #19 was free from a potential adverse outcome to medication given and/or not given per physician ordered parameters.	F 757		