STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	R 02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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 Non-Compliance Revisit. This 2567 was electronically sent to the facility on 2/22/19.	{F 000}		
{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 reported a census of 38 residents, with 4 residents reviewed for unnecessary medications. Upon interview and record review, the facility failed to ensure no unnecessary medications for 1 of the 4 sampled residents (#2),	{F 757}		

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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related to the failure to adequately monitor and utilize PRN (as needed) medications to promote bowel health.

Findings included:

- The signed physician order sheet, for resident #2 dated 11/29/2018, documented the resident had diagnoses which included constipation (difficulty passing stool).

The Admission MDS (minimum data set), dated 12/06/2018, documented the resident admitted on 11/21/2018. The resident had a BIMS (brief interview for mental status) score of 10, indicating he/she had moderately impaired cognition. The resident required extensive assistance with toilet use.

The Cognitive Loss/Dementia CAA (care area assessment), dated 12/12/2018, documented the resident had a history of constipation.

The ADL (activity of daily living) Functional/Rehabilitation CAA, dated 12/12/2018, documented the resident needed assistance with all ADLs from staff.

The POS dated and signed 01/21/2019, included a physician order for Colace, 50 mg (milligram), PO (by mouth), Q AM (daily, every morning).

A fax communication, dated 01/25/2019, documented the resident was having issues with constipation. He/She had a large, very hard, constipated BM (bowel movement) today. He/She had a current order for Colace, 50 mg, daily, routinely. The staff asked the physician if the resident could have something for this

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{F 757}	Continued From page 2	{F 757}		

constipation and also have something PRN (as needed). The PCP (primary care provider) response, dated 01/25/2019, instructed the staff to increase the Colace to 100 mg, PO, BID and to add Miralax 17 grams, PO, nightly and PRN for constipation.

The nursing notes from 02/10/2019 to 02/21/2019, lacked any documentation of bowel movements or PRN medications administered for constipation.

Review of the February, 2019 MAR (medication administration record), from 02/09/2019 to 02/21/2019, revealed the resident received the Colace, 100 mg, PO, 2 times daily, and the Miralax was administered 1 time, on 02/10/2019, which was effective with a BM.

The medical record indicated the resident had a bowel movement on 02/10/2019, 02/16/2019 and 02/20/2019. The medical record lacked documentation of a bowel movement from 2/10 through 02/15/19, a period of 5 days. The record lacked a BM documented from 02/17/19 through 02/19/19, for a period of 3 days.

On, 02/20/2019 at 1:57 PM, Direct care staff F explained the resident was able to state his/her needs and concerns, and staff assisted him/her with toileting. Staff F further explained when a resident had a bowel movement the staff charted the BM in the computer.

On, 02/20/2019 at 4:38 PM, Direct care staff G advised the resident was able to voice his/her needs and concerns, and needed assistance to the bathroom. Staff G further advised when a resident had a bowel movement the staff would

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{F 757}	Continued From page 3	{F 757}		

chart the BM in the computer, and if staff thought the resident was constipated staff would tell the nurse.

On, 02/21/2019 at 9:04 AM, License nursing staff H advised the bowel protocol directed staff when a resident did not have a bowel movement in three days, staff would give them a PRN, if the resident appeared on the list frequently and did not have something ordered, staff would try to obtain an order. Staff H further advised the resident had Colace scheduled routinely, and Miralax PRN. Staff H further advised the resident was on the "dashboard" (computer) yesterday, indicating the resident had not had a BM in 3 days, but had not looked today. Staff H further advised if there was not a bowel movement charted, then staff would ask the resident or the family, if they were with them, to see if the resident had a BM, and then chart it. Staff H further stated between February 11th and 15th the resident did not have a bowel movement, and staff failed to administer any PRN medication for constipation.

On, 02/21/2019 at 9:59 AM, Administrative nursing staff C advised, he/she ran a report on the computer everyday to check which residents had not had a bowel movement for 3 days, and then notify the nurse the resident needed a PRN medication,and staff could check the dashboard. Staff C further advised when a resident goes 8 days without a BM that is a long time, 3 days is too long. Staff C further advised there should have been a note from the nurse, and assessment of the resident, then PRN medication given. Staff C confirmed the medical record contained no notes, bowel movement documented, or PRN medications given for the

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{F 757}	Continued From page 4 dates in question. The facility policy entitled Daily Clinical Excellence, dated 12/2015, documented the daily clinical excellence was to be conducted by the Director of Nursing (DON) or designee on a daily basis at the beginning of each day and prior to the stand up meeting. The DON was responsible to assign and follow up on tasks and concerns identified during the review. The staff were to review the clinical dashboard, administer PRN (as needed) medication audit, and clinical alerts for no BM in 3 days. The facility failed to monitor the resident's bowel movements to ensure no unnecessary medications, and failed to administer the resident's PRN medication for constipation.	{F 757}		
{F 758} SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	{F 758}		

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{F 758}	Continued From page 5 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: The facility reported a census of 38 residents, with 8 residents selected for sample review, which included 3 reviewed for psychotropic medications. Based on record review and interview, the facility failed to monitor antipsychotic medications with accurate assessments for side effects, to ensure no unnecessary medications, for 1 (#21) of the 3	{F 758}		

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{F 758}	Continued From page 6	{F 758}		

residents selected for review.

Findings included:

- The physician's orders, dated 12/7/18, of resident #21, documented the resident admitted on 1/18/18, with diagnosis including dementia (progressive mental disorder characterized by failing memory, confusion), with behavioral disturbance, and sexual disorders.

The annual MDS (minimum data set), dated 3/15/18, documented the resident had a BIMS (brief interview for mental status) score of 6, which indicated the resident had severely impaired cognition for daily decision making. The resident received an antianxiety medication.

The CAA (care area assessment), for psychotropic medications, dated 3/30/18, documented the resident received an antianxiety medication.

The quarterly MDS, dated 11/30/18, documented the resident had a BIMS score of 10, which revealed moderately impaired cognition. The resident received an antipsychotic medication on a routine basis.

The discus [(Dyskinesia Identification System Condensed User Scale) an assessment tool for involuntary muscle movements], dated 1/9/19, scored 0. Staff documented the resident lacked abnormal tongue movement, and the resident's tongue did not thrust in/out of his/her mouth).

The physician's order included, Paliperidone (antipsychotic), extended release, daily, for dementia with behavioral disturbance, ordered

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{F 758}	Continued From page 7 11/17/18. On 2/20/19 at 10:30 am, the resident sat in his/her wheelchair in the hallway. The resident's tongue involuntarily thrusted in/out of his/her mouth, with/without the resident talking. On 2/20/19 at 4:41 pm, the resident continued to have involuntary tongue movements. On 2/21/19 at 8:27 am, the resident continued to have involuntary tongue movements. On 2/21/19 at 8:35 am, administrative staff E, reported the resident had an involuntary tongue thrust since he/she admitted to the facility, and identified him/herself as the staff responsible for completion of the Discus assessment. He/she verified the Discus assessment was incorrect. On 2/21/19 at 10:23 am, administrative nursing staff C, reported staff should have identified the resident's tongue movement was involuntary, and verified the Discus assessment was incorrect. The facility's policy for behavior management and psychotropic medications, dated 12/2017, documented the discus assessments should be completed on admission, readmission, quarterly, with significant change and when the resident received antipsychotic medications. The facility failed to complete an accurate Discus assessment, for monitoring the antipsychotic medication, for this resident who received an antipsychotic medication, and had involuntary tongue thrusting.	{F 758}		
{F 761}	Label/Store Drugs and Biologicals	{F 761}		

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{F 761} SS=E	Continued From page 8 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 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 reported a census of 38 residents. Based on observation and interview, the facility failed to adequately monitor expiration dates on 1 stock bottle (used for several residents) of (Calcium) medication, and failed to date 1 of 3 insulin pens, when opened for resident #5. Findings included: - Observation, on 02/19/2019 at 4:10 PM, of the	{F 761}		

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{F 761}	Continued From page 9 nurse's medication cart with License nursing staff D revealed, 3 insulin pens, the 1 insulin pen for Resident #5 lacked a date when opened. The cart also contained an opened stock bottle (used for several residents) of Calcium, 600 mg (milligram), which expired on date of 09/17. At that time, License nursing staff D explained that the insulin pen's label documented it as received in January, 2019, so the staff had to of opened it after that. License nursing staff D confirmed the insulin pen lacked an open date, and the stock bottle of calcium, the staff continued to administer to the residents, was past the expiration date, by 5 months. On, 02/21/2019 at 9:59 AM, Administrative nursing staff C, advised he/she expected all insulin pens to be dated when the staff opened them and the residents' stock medications discarded when expired. The facility policy entitled, Expired Medication Program, revised 12/2017, documented the medication's bottles and packages would be identified with a colored sticker representing the month in which the item will expire. Expired medications would be removed from supply on the last day of the month in which the item expires. The facility failed to label and store medications, within professional standards, in one of two medications carts reviewed, for resident #5 and for the residents of the facility that received stock Calcium medication.	{F 761}		
{F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	{F 880}		

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{F 880}	Continued From page 10 §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: §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,	{F 880}		

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{F 880}	Continued From page 11 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 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 had a census of 38 residents. Based on observation, review and record review the facility failed to maintain an effective infection control program with the failure to ensure adequate infection control practices provided to prevent the spread infections to the residents of the facility. Findings included: - On, 02/19/2019 at 3:35 PM, during the initial tour of the facility, the following observations	{F 880}		

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{F 880}	Continued From page 12	{F 880}		

revealed various items/areas of concern with the facility's infection control program:

1.) One resident bathroom, contained a package of incontinent briefs sitting directly on the floor.

2.) One resident bathroom, contained a package of incontinent briefs sitting directly on the floor.

3.) One resident room, contained a blanket lying directly on the floor.

4.) One resident bathroom, contained a gift bag sitting directly on the floor.

5.) One resident room, contained the resident's shoes stored directly on the seat of the walker.

6.) One resident bathroom, contained an unclean toilet riser, which held a dried brown substance on the seat side.

7.) One resident bathroom, contained a cardboard box with a red bag inside of it and sitting directly on the floor. The resident's room lacked any type of signs for the isolation.

On, 02/20/2019 at 10:35 AM, observation revealed resident #6 being placed on the toilet by staff two staff members. This observation revealed a soiled incontinent brief, soiled blue pants, a cushion, a gray lift sling, a pair of gray slacks, and a pair of bunny boots, which all were sitting directly on the floor. Following the resident's toileting, direct care I performed peri care to the front of the resident while wearing gloves and License nursing staff H assisted while wearing gloves. The resident was then raised in the lift to complete peri care, as the resident had

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{F 880}	Continued From page 13	{F 880}		

a bowel movement, and peri care was performed by Staff I. Both staff members placed and adjusted the new incontinent brief and clean pants prior to changing their gloves. Staff H and I attempted to pull up the resident's incontinent brief and clean pants, but could not, due to the sling placement. Staff I removed his/her left glove and then placed the resident in the wheelchair to adjust the clothing. Staff I replaced the glove and removed the lift from the bathroom placing it in the hallway, and placed the resident in the wheelchair and into the hallway prior to removing his/her gloves or washing his/her hands. Staff I and Staff H used the cushion, the bunny boots, the gray pants and incontinent brief after the items rested on the bathroom floor in front of the toilet.

On, 02/21/2019 at 9:04 AM, License nursing staff H advised the resident did not like the gray lift sheet and so staff obtained the blue one to use. The dark knee cushion was on the floor, it probably fell out during the first transferring of the resident onto the toilet. Staff H advised placing the clean clothes on the floor was not acceptable, the soiled brief should not have been on the floor and should have been in the trash. Staff H stated none of that was acceptable, the brief on the floor, the clean pants on the soiled pants, and the staff should change gloves after peri care. Staff H further explained that he/she did remind staff I to wash his/her hands when coming back into the bathroom.

On, 02/21/2019 at 9:59 AM, Administrative nursing staff C explained that as DON (director of nursing) he/she was was responsible for everything nursing wise which included infection control practices. The mechanical lift sling laying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. BUILDING _____ B. WING _____	R 02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES COLUMBUS	101 LEE AVENUE COLUMBUS, KS 66725

(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
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on the floor would not be acceptable. The soiled incontinent brief needed to be in the trash and soiled clothing in the laundry bag. The bunny boots and the cushion should not be on the floor. Staff C further advised the clean clothes should not be with the dirty and definitely not on the floor. The clean should never be on the floor. Staff C advised the gloves should be changed when visibly soiled or when they touch something dirty. The staff should change gloves after peri care. He/She should have taken his/her gloves off prior to taking the equipment out of the room and before assisting the resident into the hall. The staff should have removed his/her gloves first and washed his/her hands. Staff C further explained trying to educate the staff that is was not acceptable to store briefs directly on the floor, blankets on the floor, or even the gift bag on the floor. The BM on the resident's toilet riser should have been cleaned. Staff C advised he/she was confused on who was or was not on isolation and why the staff would be using the red bags. The resident in that room was not on isolation and did not know why a red bag was in that bathroom, as it made no sense to him/her.

The facility policy, entitled Infection Management Process, revised 12/2017, documented the process would assist the facility with preventing and managing infection events by all resident rooms would have standard housekeeping services at least daily. Employees would be educated with orientation and at least yearly on proper hand hygiene to include hand washing and hand sanitation. Soiled resident clothing and linens would be transported in an enclosed container to the laundry to avoid contamination to the resident living areas and to employees. Any use of red bagging required proper handling and

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{F 880}	Continued From page 15 disposal as biohazard products. The facility failed to maintain an effective infection control program to prevent the spread of infections to the residents of the facility, related to the practice found with a resident not on isolation precautions but with an isolation bag in the room, related to peri care, glove/hand washing, storage of clean and dirty resident equipment and with clean/soiled clothing directly on the floor.	{F 880}		