

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

PRINTED: 09/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175491		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2023	
NAME OF PROVIDER OR SUPPLIER HOEGER HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 20911 WEST 153RD STREET OLATHE, KS 66061			
(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 #KS00181556 & KS00181285. The 2567 was sent electronically on 09/07/23. A revised 2567 was sent electronically on 09/14/23			F 000			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 13 residents with two residents reviewed for treatment/services to prevent/heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review,			F 686			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/07/2023

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 686	Continued From page 1 and interviews, the facility failed to ensure pressure reducing measures according to the plan of care were implemented for Resident (R) 69's bilateral lower extremities and a cushion in the wheelchair to prevent worsening of pressure ulcers. This placed R69 at increased risk for pressure ulcer development and worsening of right heel pressure ulcer. Findings included: - R69's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of need for assistance for personal care, diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), epilepsy (brain disorder characterized by repeated seizures), and embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the blood stream) of lower extremities. The "Admission Minimum Data Set" (MDS) was in progress. R69's "Care Area Assessment" (CAA) was not completed. R69's "Care Plan" dated 08/20/23 documented staff would provide a pressure relieving/reducing device on the bed and in wheelchair. The "Care Plan" dated 08/23/23 documented staff would float R69's heels when in bed. Review of the EMR under "Orders" tab revealed the following physician orders: Wound order: skin prep to bilateral heels, float heels every day and night shift dated 08/19/23.	F 686			

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F 686	Continued From page 2 Review of EMR under "Assessment" tab revealed a "Wound Assessment" dated 08/23/23 which documented a stage one (pressure are with red, non-blanchable skin but not open) pressure ulcer on R69's right heel. On 08/29/23 at 12:18 PM R69 sat upright on his bed, with his left arm in a sling, and his bilateral heels rested directly on the mattress. R69's wheelchair sat next to the bed and lacked a cushion. On 08/30/23 at 07:24 AM R69 was asleep on the bed, with left arm in a sling, and his bilateral heels rested directly on the mattress. R69's wheelchair was next to the bed and lacked a cushion. On 08/30/23 09:34 AM R69 was asleep on his bed, with a sling on his left arm, and his bilateral heel rested directly on the mattress. Licensed Nurse (LN) I entered the room to apply skin prep (liquid skin barrier) to R69's bilateral heels. LN I applied skin prep to the left heel, then placed R69's left foot back on the bed. LN I opened second package of skin prep, removed R69's right sock to his toes, applied skin prep to right heel, then placed right foot back onto mattress. LN I pulled left sock back onto R69's foot and then pulled his right sock back onto his right foot and placed heels directly onto the mattress. LN I doffed gloves and removed R69's breakfast tray from room. On 08/30/23 at 12:30 PM R69 sat in his wheelchair in the dining room with out a wheelchair cushion. On 08/31/23 at 08:14 AM R69 propelled self into	F 686			

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F 686	Continued From page 3 the hallway to talk with nursing staff, no cushion was on the seat of the wheelchair. On 08/31/23 at 10:55 AM Certified Medication Aide (CMA) R stated she was not sure if R69's heels should be floated. CMA R stated she would find that information on the Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change). CMA R stated a pressure reducing cushion should be in the wheelchair most of the time. On 08/31/23 at 11:05 AM LN I stated she did not float R69's heels after his treatment because he moved his feet a lot. LN I stated every wheelchair should have a pressure reducing cushion in the wheelchair. LN I stated it was everyone's responsibility to ensure the wheelchair had a cushion. On 08/31/23 at 12:22 PM Administrative Nurse D stated all the mattresses at the facility were pressure reducing. Administrative Nurse D stated every wheelchair needed a pressure reducing cushion and R69's heels should be floated when he was in bed. Administrative Nurse D stated heels were floated on a pillow. The facility's "Skin Assessment Pressure Ulcer Prevention and documentation Requirements-Rehabilitation/Skilled" policy last reviewed 04/26/23 documented the purpose was to systematically assess residents regarding risk of skin breakdown, to accurately document observations and assessments of residents, and to appropriately use prevention techniques and	F 686			

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F 686	Continued From page 4 pressure redistribution surfaces on those residents at risk for pressure ulcers. Residents who were unable to reposition themselves independently, as indicated on the clinical assessment, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule was required for those residents unable to position themselves and was based on nutrition, hydration, incontinence, diagnoses, mobility, and observation of the resident's skin over a period of time. The Positioning Assessment and Evaluation was a required tool that is used to determine an individualized repositioning plan. The positioning schedule would be communicated to the nursing assistants using the Kardex. Any resident at risk would be placed on a pressure redistribution surface as determined appropriate.	F 686			
F 689 SS=G	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:	F 689			

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F 689	Continued From page 5 The facility documented a census of 28 residents. The sample included 13 residents with three reviewed for falls. Based on record review and interview, the facility failed to ensure a safe environment free from preventable accidents when staff failed to ensure Resident (R) 67 had foot pedals on her wheelchair before staff propelled the resident down the hallway to her room. The resident was unable to hold her legs up and placed her foot on the floor which caused the resident to fall forward out of the wheelchair. The fall resulted in a broken left femur (thigh bone). Findings included: - R67's Electronic Medical Record (EMR) from the "Diagnoses" tab documented diagnoses of weakness, altered mental status (change in mental function that stems from illnesses, disorders and injuries affecting your brain), and generalized muscle weakness. The "Admission Minimum Data Set" (MDS) dated 07/11/23 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R67 required limited assistance of one staff for many of her activities of daily living and transfers. The "Cognitive Loss /Dementia Care Area Assessment" (CAA), dated 07/11/23, documented R67 had impaired memory and a BIMS of 12. The "Falls CAA" dated 07/11/23, documented R67 had impaired gait and balance and required staff assistance with mobility.	F 689	Past noncompliance: no plan of correction required.		

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F 689	Continued From page 6 R67's "Care Plan" recorded an intervention dated 06/29/23, which documented R67 had bilateral lower extremity weakness and needed assistance with bed mobility, transfers, dressing, toilet use, and bathing. An "Incident Note" dated 07/11/23, documented R67 propelled herself to her room in her wheelchair. The note documented R67 stopped Certified Medication Aide (CMA) R and asked if CMA R could push her to her room. The note documented Licensed Nurse (LN) J heard her name being yelled and came around the corner and found R67 on the floor, on her right side, with CMA R next to her. The note documented CMA R stated R67 put her foot down, which caused her to tip out of the wheelchair. The note further documented R67 complained of left knee pain and had a skin tear to her right elbow. The note documented that the skin tear was bandaged, and R67 was assisted back into her wheelchair by staff with the use of a Hoyer lift (total body mechanical lift used to transfer residents). A "Complaint Investigation Witness Statement" dated 07/11/23, documented CMA R was walking to the kitchen when R67 asked CMA R to push her back to her room, in the wheelchair. The statement documented that CMA R asked R67 to put her feet up before pushing R67 toward her room. The statement further documented R67's feet fell, which caused her to tumble out of the wheelchair. The "Investigation Report" documented R67 propelled herself in her wheelchair when she asked CMA R to help push her back to her room. The report documented CMA R requested R67 pick her feet up before she transported her down	F 689			

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F 689	Continued From page 7 the hallway. As CMA R transported R67 down the hallway, R67's feet dropped to the floor, which caused R67 to fall forward out of the wheelchair with her arms out in front of her and she rolled to her right side after she had landed. The report further documented R67 complained of left knee pain and had a skin tear to her right upper extremity, which was dressed, and staff assisted R67 back into her wheelchair with use of the Hoyer lift. The report documented R67 received an X-Ray, for her left knee, on 07/11/23 with no acute fracture or negative findings. R67 continued to complain of bilateral knee pain, she continued on a pain regimen, and planned to discharge home with her daughter. The report documented R67 was sent to the hospital for further evaluation and was found to have a left femur fracture. On 08/31/23 at 09:50 AM CMA R stated if there were no foot pedals on a resident's wheelchair, and the resident asked to be pushed by staff, staff would have to get the foot pedals and put them on the wheelchair first. She stated staff were never supposed to push residents without having the pedals in place. On 08/31/23 at 09:54 AM LN K stated staff must make sure residents have foot pedals on their wheelchairs before pushing them. She stated if there were no foot pedals then staff could not push the residents in the wheelchairs. On 08/31/23 at 12:22 PM Administrative Nurse D stated staff were expected to have footrests in place before pushing residents in their wheelchairs. She further stated if there were no foot pedals on the resident's wheelchair, and the resident wanted to be pushed by staff, then staff were expected to find the foot pedals and put	F 689			

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F 689	Continued From page 8 them on, or the resident can self-propel. She stated the foot pedals were normally stored in a bag on the back of the wheelchair. She stated all staff had received education and signed off that they will not push residents without foot pedal on the wheelchairs. The facility policy "Fall Prevention and Management" revised 03/29/23, documented the risk of falling for residents in long-term care locations substantially increases due to decreased mobility, frailty, muscle weakness, gait disturbance and disease progression. The facility failed to ensure a safe environment free from preventable accidents when staff failed to ensure R67 had foot pedals on her wheelchair before staff propelled the resident down the hallway to her room. The resident was unable to hold her legs up and placed her foot on the floor which caused the resident to fall forward out of the wheelchair. The fall resulted in a broken left femur for R67. On 07/21/23 the facility completed corrective actions, which included education to all staff regarding wheelchair safety and ensuring footrests were in place prior to transporting residents. Footrest bags were placed on the back of each wheelchair for footrest placement when not in use to ensure availability when needed. Staff audits were conducted, and the issue was reviewed by the Quality Assurance and Performance Improvement committee. All corrective measures were completed prior to the onsite survey therefore the citation was issued as past noncompliance which existed at a "G" to represent the isolated, actual harm for	F 689			

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F 689	Continued From page 9	F 689			
F 690 SS=D	R67. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690			

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F 690	Continued From page 10 This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents. The sample included 13 residents with one reviewed for bowel and bladder management. Based on observation, record review, and interviews, the facility failed to implement individualized interventions to improve Resident (R)167's bladder incontinence or prevent further loss. This deficient practice placed R167 at risk for complications related to incontinence. Findings Included: -The "Medical Diagnosis" section within R167's Electronic Medical Records (EMR) included diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), repeated falls, chronic obstructive pulmonary disorder (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), neuralgia (severe nerve pain), and insomnia (inability to sleep). A review of the EMR indicated R167 admitted on 08/23/23. No Minimum Data Set (MDS) or Care Area Assessments were completed for R167. R167's "Care Plan" initiated 08/23/23 indicated he required extensive assistance from one staff for toileting. The plan noted he required a gait belt and limited assistance from one staff for transfers between surfaces. The plan indicated he had bladder incontinence and used incontinence briefs. The plan indicated he had a history of	F 690			

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F 690	Continued From page 11 falling related to significant changes in his safety awareness, gait, and mobility. The plan did not mention a portable urinal. The plan lacked individualized interventions or toileting program to maintain and promote R167's highest level of functioning related to incontinence. A "Bladder Evaluation" for R167 completed on 08/27/23 indicated he had daily incontinence in both day and nighttime. The evaluation indicated he used incontinence products. The evaluation noted obesity and mobility as factors related to his incontinence. The evaluation noted he used the toilet but not a bedpan or portable urinal. The evaluation recommended he be provided a toileting program and staff were to provide check/change. R167's clinical record lacked evidence staff developed and implemented a toileting program. On 08/29/23 at 10:00AM R167 sat on his bed with his bedside table pulled to him for breakfast. R167 wore only his underwear as he ate his breakfast. R167's room smelled heavily of urine and a half-full portable urinal sat next to the resident's breakfast tray. R167 stated staff had not emptied the urinal in the morning. He stated he had urinary incontinence but he was not sure if the facility had implemented a program for it. On 08/30/23 at 07:09AM a full urinal sat on R167's bedside table as he slept in his bed. On 08/31/23 at 08:23AM Certified Nurse's Aide (CNA) M stated she was not sure if R167 had a toileting program. She stated he utilized a portable urinal and staff would empty it.	F 690			

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F 690	Continued From page 12 On 08/31/23 at 09:05AM Licensed Nurse (LN) G stated R167 was not on a toileting plan. She stated he did have urinary incontinence and wore incontinence products but was not aware if any individualized interventions were in place to maintain his bladder function. On 08/31/23 at 12:23PM Administrative Nurse D stated residents were screened for incontinence upon admission. She stated staff were expected to provide toileting and peri-care to prevent skin breakdown. She stated the interventions listed on the evaluations would be implemented and available for staff to review on the Kardex. A review of the facility's "Bowel and Bladder" policy revised 04/2023 stated that resident will be evaluated for bowel and bladder incontinence management. The policy noted that residents noted without irreversible causes will be evaluated for potential bowel and bladder management. The policy noted that pattern evaluations will be provided to residents for individualized continence management programs. The policy indicated implemented interventions would have included prompted toileting, bladder training, and dietary monitoring. The facility failed to implement individualized toileting program related to urinary incontinence for R167. This deficient practice placed R167 at risk for complications related to incontinence.	F 690			
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	F 758			

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F 758	Continued From page 13 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 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.	F 758			

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F 758	Continued From page 14 §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 28. The sample included 13 residents with five residents reviewed for unnecessary medications. Based on observations, interviews, and record reviews, the facility failed to implement monitoring for behaviors and side effects associated with Residents (R)9's psychotropic medications (class of medications that chemically alter the brain to effect mood, perception, and behaviors). This deficient practice placed the residents at risk for ineffective treatment and unnecessary side effects. Findings included: - The "Medical Diagnosis" section within R9's Electronic Medical Records (EMR) included diagnoses of anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), hallucinations (sensing things while awake that appear to be real, but the mind created), and obstructive sleep apnea (absence of breathing). R9's "Quarterly Minimum Data Set (MDS)" completed 08/04/23 noted a Brief Interview for Mental Status (BIMS) score 15 indicating intact cognition. The MDS noted no behaviors. The	F 758			

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F 758	Continued From page 15 MDS noted he had antianxiety (class of medications that calm and relax people with excessive anxiety, nervousness, or tension) and antidepressant medications (class of medications used to treat mood disorders and relieve symptoms of depression). R9's "Psychotropic Medication Care Area Assessment (CAA)" completed 03/14/23 indicated he was being treated for mood disorder and took alprazolam (antianxiety medication). The CAA also indicated he took escitalopram (antidepressant medication). R9's "Psychosocial Well-being CAA" completed 03/14/23 indicated he had little desire to participate in his favorite activities. A review of R9's "Care Plan" initiated 03/13/23 indicated he took antianxiety medication. The plan indicated staff were to monitor and document the medications side effects and effectiveness. The plan instructed staff to monitor R9's condition based on clinical practice guidelines or clinical standards of practice related to the alprazolam. The plan noted he took antidepressant medication. The plan instructed staff to monitor R9's condition based on clinical practice guidelines or clinical standards of practice related to the escitalopram (antidepressant medication). R9's EMR indicated under "Physician's Orders" he received alprazolam (0.25 milligrams (mg)) two times a day for mood started 04/27/23. R9's EMR indicated under "Physician's Orders" he received escitalopram (10mg) one time daily for mood.	F 758			

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F 758	Continued From page 16 A review of R9's EMR revealed no documentation showing staff consistently monitored the alprazolam and escitalopram's side effects or behaviors for the medication effectiveness and continued use. On 08/31/23 at 09:54AM, Licensed Nurse (LN) K stated staff should be documenting side effects and behaviors in the progress notes as they occurred. She stated she was not sure of any other place it could be documented in the EMR. She stated the direct cares staff would any behaviors observed to the nurse for documenting. On 08/31/23 at 12:24PM Administrative Nurse D stated behaviors were not documented on an everyday basis; they were put in the EMR as needed. She stated staff would put in progress notes if behaviors occurred or might also be listed in tasks section or in an assessment. She stated behaviors usually were more stable due to the facility being short stay and the residents were more adjusted to their medications. She stated if the residents had behaviors social services would assess and report what behaviors needed to be monitored. A review of the facility's "Psychotropic Medications" revised 12/2022 indicated the facility must provide documentation of psychotropic medications side effects and behavioral monitoring for residents on the medications. The Policy indicated documentation would include mood, behavior changes, sleep disturbances, restlessness, dizziness, nausea, or any adverse reactions associated with the class of medications.	F 758			

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F 758	Continued From page 17 The facility failed to implement monitoring for behaviors and side effects associated with R9's alprazolam and escitalopram medications. This deficient practice placed the residents at risk for ineffective treatment and unnecessary medication side effects	F 758			
F 761 SS=D	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 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 had a census of 28 residents. The sample included 13 residents. Based on	F 761			

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F 761	Continued From page 18 observation, interview, and record review, the facility failed to label Resident (R)218's insulin (hormone which allows cells throughout the body to uptake glucose) pen with the date opened and discard date and failed store his medications securely. This placed R218 at risk for ineffective or diverted medications. Findings included: - On 08/29/23 at 07:10 AM an observation in the cabinet outside of R218's room revealed an unlocked medication storage drawer that contained the following: R218's Humalog (fast-acting insulin) pen. The pen lacked a date opened, and discard date. R218's Lantus (long-acting insulin) pen. The pen lacked a date opened, and discard date. Seven cards that contained various prescription medications. The inside of the cabinet door revealed a sign that documented insulin expired 28 days after opening. On 08/29/23at 07:23 AM Licensed Nurse (LN) I stated medication drawers should be locked if not being used. She stated that the insulin pens were R218's home medications, and she was not sure when they were opened. She further stated insulins were no longer good if opened for longer than 28 days. On 08/31/23 at 12:22 PM Administrative Nurse D stated medication drawers should always be locked if no one was present. She stated that on average, most insulins expired 28 days after they were opened. She stated there were some exceptions, with certain insulins that lasted longer than 28 days and that had been discussed with	F 761			

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F 761	Continued From page 19 their pharmacy consultant; however, she was unsure if the policy had been updated to reflect those changes. The facility policy "Medications: Acquisition Receiving Dispensing and Storage" revised 03/02/23, documented medications will be stored in a locked medication cart, drawer, or cupboard. Only the person passing medication and the director of nursing services and/or designees will be permitted to have access to the keys to the medication storage areas. The location will routinely check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations. The facility failed to label R218's insulin pens with the dates opened and discard dates and failed to store his medications securely. This placed R218 at risk for ineffective or diverted medications.	F 761			
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812			

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F 812	Continued From page 20 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility identified a census of 28 residents with one kitchen and one kitchenette. Based on observation, record review, and interviews, the facility failed to maintain sanitary dietary standards related to sanitary food and equipment storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns. Findings Included: - On 08/29/23 at 07:05AM a walkthrough of the facility's kitchen was completed. An inspection of the facility's freezer unit revealed opened but undated/unlabeled bags of potato wedges, breaded meat patties, and sliced strawberries. An inspection of the equipment storage rack revealed a large pasta strainer on the top shelf stored upward (not inverted) towards the ceiling. An inspection of the facility's deep fryer station revealed a sheet pan covering the fryer unit. Large amounts of old food particles floated in the oil at the top of the deep fryer unit. An inspection of the preparation area revealed dust/debris covering the spice bottles on the rack. On 08/29/23 at 08:30AM a walkthrough of the facility kitchenette was completed. An inspection	F 812			

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F 812	Continued From page 21 of the kitchenette's microwave revealed old food particles inside the cooking unit. An inspection of the kitchenette's refrigerator/ top freezer unit revealed three upon and undated one-gallon ice cream containers. The upper freezer unit also contained a frost covered black grocery bag with unknown contents inside. The lower refrigerator unit contained opened condiments and an unlabeled jar of salsa. On 08/31/23 at 09:02AM Dietary Staff BB indicated staff were expected to clean each kitchen area daily and in between services. He stated kitchen staff would clean the ovens and deep fryer daily after use and filter out the oil daily. He stated a deep clean of the kitchen was to be completed once weekly including a checking the food products for refrigerator labels and dates. He stated all open food should be labeled with the open date and rotated out before expiration. He stated the kitchenette was cleaned weekly and staff should not be leaving personal food in it. A review of the facility's "Food and Equipment Storage" revised 05/2023 policy noted that all food preparation areas and equipment will be maintained in a clean serviceable manner. The policy noted all equipment used in the handling of food shall be cleaned, sanitized, and handled in a manner that prevents contamination. The facility failed to maintain sanitary dietary standards related to food and equipment storage. This deficient practice placed the residents at risk related to food borne illnesses and food safety concerns.	F 812			
F 880 SS=F	Infection Prevention & Control	F 880			

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F 880	Continued From page 22 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: §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	F 880			

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F 880	Continued From page 23 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 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 28 residents. The sample included 13 residents. Based on record review, observations, and interviews, the facility failed to track and analyze infectious organisms related to its infection surveillance. The facility also failed to follow transmission-based precautions during wound care for Resident (R)169. This deficient practice placed the residents at risk related to infectious diseases.	F 880			

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F 880	Continued From page 24 Findings included: - Review of the facility "Antibiotic Stewardship Surveillance Logbook" from July 2022 to July 2023 revealed that the contributing organism was not being tracked with trends noted on the surveillance log. On 08/31/23 at 09:25 AM Administrative Nurse E stated she was the Infection Preventionist since September 2022 and was certified since December 2022. Administrative Nurse E stated she had not been told that the causative organism or bacteria needed to be listed or tracked. Administrative Nurse E stated she was taught that only the antibiotic needed to be listed with the start date and resolution date. The "Infection Prevention and Control Program" policy last revised 02/15/22 documented: The infection prevention and control program will attempt to meet federal and state regulations for infection control where applicable. The program included infection prevention, control and education. The infection preventionist and the Quality Assurance and Performance Improvement (QAPI) committee would direct the functions of the infection and prevention and control program. The system of identifying, reporting, investigating, and controlling infections and communicable diseases for all residents will be tracked where possible on the Infection and Antimicrobial Tracing Tool and reviewed by the who will keep a record of any corrective action taken. The facility failed to track and analyze organisms for infection surveillance. This deficient practice	F 880			

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F 880	Continued From page 25 placed the residents at risk related to infectious diseases. - The "Medical Diagnosis" section within R169's Electronic Medical Records (EMR) included diagnoses of type two diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), neuralgia (severe nerve pain), insomnia (inability to sleep), fracture of left humerus (break in upper arm bone), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and dementia (progressive mental disorder characterized by failing memory, confusion). A review of the EMR indicated R169 admitted on 08/16/23. No Minimum Data Set (MDS) or Care Area Assessments were completed yet for R169. R169's EMR under "Physician's Orders" revealed an active order dated 08/28/23 indicating "Enhanced Barrier Precautions" (precautions that required staff to complete hand hygiene, don gloves, and wear gowns while high contact cares activities were provided to residents with wounds, indwelling medical devices, or had multidrug resistant organism infections) were implemented related to a Methicillin-resistant Staphylococcus aureus (MRSA - a type of bacteria resistant to many antibiotics) infection on his right shoulder. The order indicated a sign was placed on his door to alert staff to apply the proper personal protective equipment (PPE) during high contact cares on all shifts. R169's EMR revealed a "Wound Culture" completed on 08/24/23. The culture indicated he	F 880			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175491	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2023
NAME OF PROVIDER OR SUPPLIER HOEGER HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 20911 WEST 153RD STREET OLATHE, KS 66061		
(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 880	Continued From page 26 tested positive for heavy growth of MRSA on his right chest and neck. On 08/29/23 at 07:43AM an inspection of R169's room revealed an "Enhanced Barrier Precaution" sign on R169's entry door. The sign indicated all entrants must complete hand hygiene when entering and exiting the room. The sign indicated staff were required to wear protective gloves and gowns when high contact care activities were provided. On 08/29/23 at 03:20PM, R169's "Enhanced Barrier Precaution" sign was not posted on his door. On 08/30/23 at 09:13AM, R169's "Enhanced Barrier Precaution" sign was not posted on his door. On 08/30/23 at 03:35PM, Licensed Nurse (LN) H and Consultant HH prepared outside R169's room for wound care. LN H reviewed R169's orders before entering the room. R169's door had no enhanced barrier precautions signage posted at the time of entry. LN H completed hand hygiene and donned gloves. LN H assisted R169 to sit on the side of the bed and removed R169's shirt. LN H completed hand hygiene and changed her gloves. Consultant HH assessed R169's right side shoulder wound and instructed LN H to clean the wound, but said it would not require a dressing to cover due to the healing stage. LN H cleansed the wound with a saline solution and placed a clean shirt on R169. Both staff completed hand hygiene and exited the room. Neither staff wore a gown during the encounter. On 08/31/23 at 10:03AM an "Enhanced Barrier	F 880			

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NAME OF PROVIDER OR SUPPLIER HOEGER HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 20911 WEST 153RD STREET OLATHE, KS 66061		
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F 880	Continued From page 27 Precautions" sign was again on R169's door. On 08/31/23 at 09:14AM, Certified Nurses Aid (CNA) M stated she was assigned to care for R169 but was not sure if he was still on enhanced barrier precautions. She stated the nurse instructed staff which residents were on precautions, or the signs would be placed on the door. She stated staff were to complete hand hygiene, don gloves, and wear gowns for residents on enhanced barrier precautions. She stated she would ask the nurse. On 08/31/23 at 09:21AM, LN G stated residents on enhanced barrier precautions should have an order in the EMR or a sign on their door. She stated she was not sure if R169 was still on precautions but would check his orders. On 08/31/23 at 12:24PM, Administrative Nurse D stated all residents on enhanced barrier precautions would have signs on the door indicating the required personal protective equipment (PPE) required to perform cares. She stated staff were expected to completed hand hygiene and were gloves/gowns for all cares. She stated the resident's physician orders should also have reflected if the resident required the precautions. A review of the facility's "Transmission Based Precautions" revised 12/2021 indicated special precautions were meant to reduce the transmission of contagious organism between residents and lower the risks of healthcare associate illness and infections that lead to hospitalizations and death A review of the facility's "Multi-drug Resistant	F 880			

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F 880	Continued From page 28 Organisms" policy revised 02/2022 indicated enhanced barrier precautions expanded the use of PPE beyond situations in which exposure to blood and body fluids was anticipated and referred to the use of gown and gloves during high-contact care activities. The facility failed to ensure transmission based precautions were followed during R169's wound care. This deficient practice placed R169 and other residents at risk related to the spread of infectious diseases.	F 880			