STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175124	A. BUILDING _____ B. WING _____	C 07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT EL DORADO, LLC	1313 S HIGH STREET EL DORADO, KS 67042

(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 complaint investigations #171960, #171841, and # 171756. This 2567 was electronically sent to the facility on 07/11/22. This revision was electronically sent to the facility on 08/11/22.	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, including three residents reviewed for medication	F 757	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/11/2022

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administration. Based on observation, interview and record review, the facility failed to administer six different medications for one Resident (R)1, for five days during her respite (short period) care.

Findings Included:

- The signed "Physician Order Sheet" (POS), dated 05/13/22, documented the resident had the following diagnoses; atrial fibrillation (rapid, irregular heartbeat), hyperlipidemia (condition characterized by hyperactivity of the thyroid gland), hypertension (elevated blood pressure), Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), myocardial infarction (heart attack), and cardiovascular attack (any abnormal condition characterized by dysfunction of the heart and blood vessels).

The Entry "Minimum Data Set" (MDS), dated 05/12/22, documented the resident admitted from community on 05/12/22.

The planned Discharge "Minimum Data Set" MDS), dated 05/16/22, revealed the resident discharged to the community. The resident had a "Brief Interview of Mental Status" (BIMS) score of one, indicating severely impaired cognition. The resident required supervision by staff with mobility, transfer, dressing, toileting, and personal hygiene. The resident discharged on 05/16/22. The resident was in the facility for a total of five days.

The baseline care plan, dated 05/12/22, documented the resident as confused. The resident required assist of one staff member for

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bed mobility, transfer, walking, toileting, grooming/hygiene and bathing.
The signed "Physician Order Sheet" (POS), dated 05/13/22, included the following medications into their Electronic Medical Administration Records for R1:

1. Escitalopram (medication used to treat depression and anxiety) 5 milligrams (mg), take one tablet, by mouth, every morning.

2. Furosemide (diuretic - medication to promote the formation and excretion of urine), 40 mg, take one-half tablet, by mouth, every morning.

3. Levothyroxine (medication used to treat an underactive thyroid), take one tablet, by mouth, every morning.

4. Lovastatin (medication used to treat high cholesterol), 20 mg, take one tablet, by mouth, every morning.

5. Mag (Magnesium) Oxide (medication used to prevent and treat low amounts of magnesium in the blood), 400 mg, take one tablet, by mouth, every morning.

6. Spironolactone (medication used to treat high blood pressure and heart failure), 25 mg, take one-half tablet, by mouth, every morning.

The EMAR (electronic medication administration record, lacked administration of the above listed medications.

On 05/13/22 at 04:28 PM, LN G documented in the clinical notes that the physician sent an acknowledgement fax related to the resident's

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medications, and the physician replied the medication list was correct.

On 07/07/22 at 08:33 AM, Administrative Staff A reported that the resident admitted on 05/12/22 for respite care for five days. There were contradicting concerns with the resident's medication orders. Our facility did not ensure the physician's orders had been clarified as they should have been. Staff did not enter the resident's medications into the EMAR so R1 would receive her medications as ordered.

On 07/07/22 at 09:58 AM, Administrator Nurse D reported the resident admitted on 05/12/22 for respite care for five days. Licensed Nurse H admitted the resident. LN G entered the orders for Aspirin and buspirone (medication to treat anxiety). It was at that time that LN H noted the medication list from her physician contradicted the Pharmacy list. LN H made phone calls to her primary care doctor for clarification as well as sent a fax to her primary doctor with a copy of the medication list for review. On 05/13/22, LN G received a fax from her primary doctor indicating the medication list looked good. LN G failed to review the physician's order sheet and ensure the medications were entered into the Electronic Medical Records (EMAR). Administrative Nurse D reported she did not follow- up with LN G to ensure the signed order came back from the doctor.

On 07/07/22 at 11:18 AM, a family member reported the resident admitted to the facility for respite care for five days. The facility required her medications came from the pharmacy in bubble type packaging. When the resident discharged, the family reported the medications in the six

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medication bubble packs had not been administered. I picked up my mother and noted that the bubble backs were full of the exception of Buspirone and the aspirin.

On 07/07/22 at 05:55 PM, Licensed Nurse (LN) H reported the resident admitted on 05/12/22 at approximately 01:00 PM. LN H reported she entered Aspirin and Buspirone into the EMR, then noticed that the resident's medication list and the pharmacy list did not match, so she stopped entering the medications into the EMR. She made calls to the resident's physician as well as faxed the physician for clarification orders. LN H reported that she reported the information on to Administrative Nurse D and the following shift nurse.

On 07/08/22 at 08:45 AM, LN G reported she arrived at work at 06:00 AM, the resident admitted for respite care. On 05/13/22, after 04:00 PM, LN G reported that she received a fax from the resident's physician with a physician signature that the "Med list looks good". LN G reported she failed to check the EMR to verify the medications were in the system.

The "Medication Administration Policy", undated, documented that all medications will be administered to every elder as ordered by a physician in a safe and a sanitary manner.

The facility failed to administration of medications for one Resident (1), of the three sampled residents when Licensed Nurse G failed to enter the resident's Physician Order Sheet, upon receiving the signed fax from the primary care physician. The failure resulted in the resident did not receive her medications for the five days she

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F 757	Continued From page 5 resided in the facility. This citation was considered to be past non-compliance, when the facility corrected the deficient practice, with implementation and completion of the following items, on 05/24/22: The "Hot Rack" has been placed in the East Nurses' station and will be added to the West Nurses' Station when that side is opened. 1.The Hot Rack consists of 3 bins, Orders to Input, 2nd Nurse order to review, DON Box. 2. Education to LPN charge nurse on 05/19/22 on failure to verify accuracy of orders in the medical record. 3. Audits completed and continued 3 days a week on all new orders. 4. Results of all observations and audits brought to the Quality Assurance/ Assessment Committee for review and action plans developed if indicated.	F 757		