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 _____	02/16/2023

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 a Health Resurvey and Complaint Investigation #177728. The 2567 was sent electronically on 02/24/23.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/24/2023

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F 657	Continued From page 1	F 657		

The facility had a census of 32 residents. The sample included 14 residents. Based on observation, record review and interview, the failed to review and revise Resident (R) 10's plan of care with resident-centered interventions to prevent falls, which placed the R10 at risk of further falls and injury.

Findings included:

- R10's Electronic Medical Record (EMR) recorded diagnoses of acute respiratory distress, agoraphobia (extreme fear of entering crowded places, leaving one's home, or being in places from which escape is difficult) with panic disorder, anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues) , anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, cachexia (weakness and wasting of body due to severe chronic illness), chronic kidney disease, chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) with exacerbation, dependence on supplemental oxygen, major depressive (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) disorder, memory deficit following other cerebrovascular (any abnormal condition characterized by dysfunction of the heart and blood vessels) disease, dementia (progressive mental disorder characterized by failing memory, confusion), pain, psychotic (any major mental disorder characterized by a gross impairment in reality testing) disturbance, embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck

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F 657	Continued From page 2	F 657		

while traveling through the blood stream) and thrombosis (clot that developed within a blood vessel) of unspecified deep veins of right lower extremity.

The "Significant Change Minimum Data Set" (MDS), dated 01/13/23, documented R10 had severe cognitive impairment, inattention and disorganized thinking behaviors which fluctuated, and required limited assistance of one staff for activities of daily living (ADL). R10 was not steady and only able to stabilize with staff assistance and used a wheelchair for mobility. R10 was occasionally incontinent of urine. The MDS further documented R10 had dementia, anxiety, depression, and shortness of breath with exertion. R10 had a condition or chronic disease that may result in a life expectancy of less than six months, and had not fallen since prior assessment. R10 received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), anticoagulant (preventing blood from clotting) and diuretic (increased formation and secretion of urine) daily, used oxygen and received hospice care (care provided for terminal illness/condition).

The "Fall Care Area Assessment" (CAA), dated 01/20/23, documented R10 had contributing factors which included history of falls, had weakness and physical performance limitations which affected balance, gait, strength, and muscle endurance. The CAA documented the care plan would be initiated/reviewed to coordinate care with hospice in order to provide comfort and dignity throughout the end-of-life process as it relates to ADL, mobility, decreased fall risk, and minimized injury related to falls.

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F 657	Continued From page 3	F 657		

The "Fall Care Plan," dated 01/23/23, documented R10 at risk for falls, required assistance of one staff for transfers, and directed staff to remind R10 to ask for assistance with transfers and ambulation, observe for changes in condition that may warrant increased supervision/assistance and to notify the physician. The care plan further documented R10 used a wheelchair for long distance mobility. On 02/07/23 the care plan updated to not leave R10 alone in her room in a wheelchair.

The "Progress Note", dated 01/05/23 at 05:49 PM, documented R10 was seated with bottom on the floor and both lower extremities bent at the knees. R10 verbalized she could not lie down, staff transferred resident into her wheelchair. R10 was observed without oxygen on, and pursed lipped breathing with oxygen saturation at 80 percent (%). No injuries noted at that time, skin was intact. The note recorded a mattress would be placed on the floor and care plan would be implemented. This intervention was not placed on the care plan.

The "Investigation Report" dated 01/05/23, documented R10's intervention was to have the bed lowered to the floor and a fall mat placed.

The "Progress Note", dated 01/06/23 at 01:09 AM, documented staff found R10 in the bathroom without calling for assistance; R10 was a high fall risk and had fallen shortly after her arrival to the facility.

The "Progress Note", date 01/19/23 at 01:19 PM, documented R10 was seated in her wheelchair to have lunch, and was found sitting on the floor with her legs crossed. The cushion of the wheelchair

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F 657	Continued From page 4	F 657		

was sitting on the floor. R10 was quoted "I wanted on the floor, so I put myself on the floor, I want to fall, fall, fall." The note further documented staff obtained Dysem (anti-slip material) for R10's wheelchair. Dysem addition was not added/updated on the care plan. The note further recorded staff would order a fall mat.

The "Investigation Report" dated 01/19/23, documented R10's fall intervention was to have hospice review medications.

The "Progress Note", dated 01/20/23 at 06:43 PM, documented R10 lying on the floor on her left side with two Certified Nurse Aides (CNA's) by her side. R10 stated she was trying to go to the bathroom when she lost her balance and fell. R10 demonstrated range of motion with no difficulty to arms and legs.

The "Investigation Report" dated 01/20/23 documented the intervention was to follow the care plan.

The "Progress Note", dated 02/07/23 at 12:41 PM, documented R10 was found on the floor in front of her wheelchair. Staff assisted R10 off the floor and into bed. No injuries found at that time.

The "Investigation Report" dated 02/10/23 documented the intervention was to not leave R10 alone in room when in her wheelchair.

On 02/14/23 at 02:56 PM, observation revealed R10 in bed, bed low to ground, large mat next to bed. The head of the bed was slightly elevated and R10 had her eyes closed and oxygen administration via nasal cannula.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 5	F 657		

On 02/15/23 at 01:57 PM, CNA M reported to prevent further falls for R10, the staff have a fall mat, low bed and currently R10 rarely got out of bed.

On 02/15/23 at 01:59 PM, Licensed Nurse (LN) G reported to prevent falls for R10, LN G checked every hour, offered water or something to eat. LN G stated staff were to check and change residents every two hours, and R10 had a fall mat next to her bed. LN G stated when a resident fell, the nurse checked the condition of the residents and rendered what care was needed, then the nurse management, physician, and resident's responsible party was notified of the fall. The investigation and care plan updates were done by nurse management, which placed fall interventions in the care plans.

On 02/15/23 at 11:43 AM, Administrative Nurse G reported on 01/20/23 an investigation had not been completed when R10 had been found partially on the mat and floor. Administrative Nurse G further stated the incident was not considered a fall, due to the fact R10 had placed herself on the mat, and the baseline care plan stated R10 could place herself on the mat. Administrative Nurse G stated her interpretation was that R10 had not fallen. Administrative Nurse G stated the baseline care plans had not been updated to the comprehensive care plan.

The facility's undated "Resident Directed Care Plan" policy documented it is the policy of this facility to provide an individualized, interdisciplinary plan of care for all residents that is appropriate to the resident's needs, strength, limitations and goals based on initial, recurrent and continual needs of the resident. All staff using

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F 657	Continued From page 6 the plan of care is responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluation and revision. The care plan may be amended at anytime the team determines it is necessary to ensure the resident receives appropriate care and services. The facility failed to review and revise interventions to the care plan to prevent falls placing R10 at risk for further falls and injury.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 and the sample included 14 residents, with seven reviewed for accidents. Based on observation, record review and interview the facility failed to identify and implement interventions to prevent falls for Resident (R)10 and failed to apply antiroll back devices to R20's wheelchair to prevent further falls, which placed the residents at risk for ongoing falls and injuries. Findings included: - R10's Electronic Medical Record (EMR) recorded diagnoses of acute respiratory distress,	F 689		

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F 689	Continued From page 7	F 689		

agoraphobia (extreme fear of entering crowded places, leaving one's home, or being in places from which escape is difficult) with panic disorder, anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues) , anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, cachexia (weakness and wasting of body due to severe chronic illness), chronic kidney disease, chronic obstructive pulmonary disease (COPD - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) with exacerbation, dependence on supplemental oxygen, major depressive (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) disorder, memory deficit following other cerebrovascular (any abnormal condition characterized by dysfunction of the heart and blood vessels) disease, dementia (progressive mental disorder characterized by failing memory, confusion), pain, psychotic (any major mental disorder characterized by a gross impairment in reality testing) disturbance, 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) and thrombosis (clot that developed within a blood vessel) of unspecified deep veins of right lower extremity.

The "Significant Change Minimum Data Set" (MDS), dated 01/13/23, documented R10 had severe cognitive impairment, inattention and disorganized thinking behaviors which fluctuated, and required limited assistance of one staff for activities of daily living (ADL). R10 was not steady and only able to stabilize with staff assistance and

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F 689	Continued From page 8	F 689		

used a wheelchair for mobility. R10 was occasionally incontinent of urine. The MDS further documented R10 had dementia, anxiety, depression, and shortness of breath with exertion. R10 had a condition or chronic disease that may result in a life expectancy of less than six months, and had not fallen since prior assessment. R10 received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), anticoagulant (preventing blood from clotting) and diuretic (increased formation and secretion of urine) daily, used oxygen and received hospice care (care provided for terminal illness/condition).

The "Fall Care Area Assessment" (CAA), dated 01/20/23, documented R10 had contributing factors which included history of falls, had weakness and physical performance limitations which affected balance, gait, strength, and muscle endurance. The CAA documented the care plan would be initiated/reviewed to coordinate care with hospice in order to provide comfort and dignity throughout the end-of-life process as it relates to ADL, mobility, decreased fall risk, and minimized injury related to falls.

The "Fall Care Plan," dated 01/23/23, documented R10 at risk for falls, required assistance of one staff for transfers, and directed staff to remind R10 to ask for assistance with transfers and ambulation, observe for changes in condition that may warrant increased supervision/assistance and to notify the physician. The care plan further documented R10 used a wheelchair for long distance mobility. On 02/07/23 the care plan updated to not leave R10 alone in her room in a wheelchair.

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F 689	Continued From page 9	F 689		

The "Progress Note", dated 01/05/23 at 05:49 PM, documented R10 was seated with bottom on the floor and both lower extremities bent at the knees. R10 verbalized she could not lie down, staff transferred resident into her wheelchair. R10 was observed without oxygen on, and pursed lipped breathing with oxygen saturation at 80 percent (%). No injuries noted at that time, skin was intact. The note recorded a mattress would be placed on the floor and care plan would be implemented. This intervention was not placed on the care plan.

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F 689	Continued From page 10	F 689		

The "Progress Note", dated 01/20/23 at 06:43 PM, documented R10 lying on the floor on her left side with two Certified Nurse Aides (CNA's) by her side. R10 stated she was trying to go to the bathroom when she lost her balance and fell. R10 demonstrated range of motion with no difficulty to arms and legs.

The "Investigation Report" dated 01/20/23 documented the intervention was to follow the care plan.

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The "Investigation Report" dated 02/10/23 documented the intervention was to not leave R10 alone in room when in her wheelchair.

On 02/14/23 at 02:56 PM, observation revealed R10 in bed, bed low to ground, large mat next to bed. The head of the bed was slightly elevated and R10 had her eyes closed and oxygen administration via nasal cannula.

On 02/15/23 at 01:57 PM, CNA M reported to prevent further falls for R10, the staff have a fall mat, low bed and currently R10 rarely got out of bed.

On 02/15/23 at 01:59 PM, Licensed Nurse (LN) G reported to prevent falls for R10, LN G checked every hour, offered water or something to eat. LN G stated staff were to check and change residents every two hours, and R10 had a fall mat next to her bed. LN G stated when a resident fell, the nurse checked the condition of the residents

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F 689	Continued From page 11	F 689		

and rendered what care was needed, then the nurse management, physician, and resident's responsible party was notified of the fall. The investigation and care plan updates were done by nurse management, which placed fall interventions in the care plans.

On 02/15/23 at 11:43 AM, Administrative Nurse G reported on 01/20/23 an investigation had not been completed when R10 had been found partially on the mat and floor. Administrative Nurse G further stated the incident was not considered a fall, due to the fact R10 had placed herself on the mat, and the baseline care plan stated R10 could place herself on the mat. Administrative Nurse G stated her interpretation was that R10 had not fallen. Administrative Nurse G stated the baseline care plans had not been updated to the comprehensive care plan.

The facility's undated "Fall Prevention Protocol", documented the facility would provide services and care that ensures the elder's environment remains as free from accident hazards as is possible and each elder receives adequate supervision and assistive devices to prevent accidents. The interdisciplinary team developed a plan for service to prevent accidents. Each team member is responsible for checking the care plan of the elders who are at risk for falls when beginning each day and throughout the assigned shift.

The facility failed to identify and implement interventions to prevent falls for R10, which placed the resident at risk for ongoing falls and injuries.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 12	F 689		

- R20's Electronic Medical Record (EMR) documented diagnoses of osteoporosis (medical condition in which the bones become brittle and fragile), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), hypertension (high blood pressure), and insomnia (persistent problems falling and staying asleep.

The "Quarterly Minimum Data Set" (MDS), dated 12/30/22, documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R20 was independent with eating, required limited staff assistance for locomotion, extensive assistance for bed mobility, transfers, dressing, toileting, and hygiene. The MDS documented R20 did not walk, had unsteady balance and used a wheelchair for mobility. The MDS documented R20 had no falls since the prior MDS, received antipsychotic (type of drug used to treat symptoms of psychosis), and antidepressant medications (drugs used to treat depression).

The "Fall Care Plan," dated 01/31/23, stated R20 was at risk for falls, had a history of falling before admission, and reported dizziness at times when standing up. The care plan directed staff to provide a wheelchair for long distance mobility; gait belt, walker, and assistance of one staff to ambulate. Place a Dysem (non-slip material) pad in the recliner to prevent the resident from sliding out of the chair. Ensure R20's bedroom door stayed open at all times, and do not leave R20 unattended in the bathroom. Offer R20 assistance to the bathroom every two to three hours and as needed. Ensure R20 had gripper socks or shoes on at all times. Replace call light

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 689	Continued From page 13	F 689		

button with a pancake style and ensure R20's wheelchair was locked and next to the bed. Staff educated R20 to ask for assistance with transfers. The care plan revisions for 2022 included:
02/21/2022 Low bed and fall mat added to her room.
02/22/22-Keep wheelchair out of sight when in bed.
04/02/22- Keep wheelchair beside her bed. She will attempt to walk if she cannot see it.
06/16/22 place anti-roll back bars on her wheelchair. Encourage her to go to the BR before she goes to bed.
10/20/2022 remind her to call for assistance to go to the bathroom. she often does not remember.
12/06/22 ask R20 every 2-3 hours and as needed to use restroom. Remind her, if needed, to ask for assist for transfers and ambulation.

The "Cognition Care Plan" stated R20 was alert and oriented with forgetfulness.

The "Fall Risk Assessments," dated 03/20/22, 06/16/22, 9/21/22, and 12/25/22 all documented R20 was at high risk for falls.

The "Progress Note," dated 06/16/22 at 09:50 AM, documented staff found R20 on her knees beside her bed, lying face down across the mattress. Her left arm was twisted and caught between the bed rails and the mattress. R20 stated she could not breathe, and staff lifted her face up. R20 had activated the call light, had shoes on, but her wheelchair was not locked. Staff notified the physician and called emergency services.

The "Fall Investigation Report," dated 06/17/22,

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 _____	02/16/2023

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 689	Continued From page 14	F 689		

documented R20's current BIMS score was 13 and she was able to make needs known and understand others. R20 was care planned for assistance of one staff for transfers, however she frequently transferred self despite education on risks. Staff placed antiroll back devices on her wheelchair.

The "Fall Note," dated 10/18/22 at 05:06 PM, documented at 11:15 AM the nurse found R20 lying on her left side with her left arm underneath her body and left hand barely visible on floor horizontal to her bed. R20 was able to verbalize she was attempting to go to the bathroom, (her call light was not on), had hit her head and her head hurt. Once transferred to the toilet it was noted she had deformity to her left pinky and the corresponding knuckle was swollen. Also, R20 was noted to have a golf ball sized raised abrasion to the left side of her forehead. Once transferred back to her wheelchair she was taken into the nurse's station for close observation. Staff notified family and her physician who ordered staff to send R20 to the emergency room. The note documented as R20 was leaving she was becoming drowsy, continued to complain of head and pinky finger pain. R20 was able to give a description of her fall and verbalized falling and hitting her head on the floor.

The "Progress Note," dated 10/18/22 at 05:48 PM, documented at 03:15 PM, R20 returned to the facility, continued to complain of headache, and the contusion (region of injured tissue or skin in which blood capillaries have been ruptured) to her forehead has become larger than golf ball sized. R20's left 5th finger was splinted, and the X-ray from showed a slightly displaced fracture of the left 5th finger. The note document staff found

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 _____	02/16/2023

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 689	Continued From page 15	F 689		

a large six-centimeter (cm) bruise on her left forearm. R20 was able to eat and answer simple questions appropriately.

The "Fall Note," dated 12/06/22 at 05:30 PM, documented staff found R20 lying on the floor in her room on her right side with her right arm under her body. The wheelchair was facing her, and the wheels were locked. The bed rail was up, neurological and vital signs were baseline and intact. R20 denied pain or hitting her head. R20 had a nickel sized skin tear on right forearm which the nurse cleaned, moved the skin flap back into place and applied steri-strips.

On 02/14/23 at 07:45 AM, observation revealed R20 in a low bed, mat in front of the bed, room door open, call light in reach, and one side rail up. The side rail had approximately 4.5 by 12-inch gaps between the bars.

On 02/15/23 at 04:10 PM, observation revealed R20 seated in a wheelchair in the dining room. The wheelchair did not have antiroll back devices. Administrative Nurse D was notified and verified no antiroll back device was on the wheelchair.

On 02/16/23 at 07:54 AM, observation revealed R20 sat in a wheelchair in the dining room without an antiroll back device on the wheelchair.

On 02/16/23 at 09:15 AM, observation revealed Licensed Nurse (LN) H transferred R20 from her wheelchair to bed. No wheelchair antiroll back device was noted and LN H did not know if the device was supposed to be on R20's wheelchair.

On 02/16/23 at 09:15 AM, LNG and Certified Medication Aide (CMA) R both stated they were

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 _____	02/16/2023

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 689	Continued From page 16	F 689		

unaware if R20's wheelchair should have an anti-roll back device.

On 02/16/23 at 09:30 AM, Administrative Nurse D stated R20's wheelchair should have an antiroll back device as currently care planned. Adminsitrative Nurse D acknowledge he intervention to remind R20 to use the call light may not be effective.

The facility's "Fall Prevention Protocol," undated, stated each elder at this facility would be provided services and care that ensured their environment remained as free from accident hazards as possible and each resident would receive adequate supervision and assistive devices to prevent accidents. The policy directed staff to ensure optimal communication regarding the resident's potential for falls with other care providers. The interdisciplinary team would develop a plan for services and interventions to reduce the risk of falls. Every team member would be responsible for checking the care plan for residents at risk for falls when beginning each shift. The effectiveness of the fall reduction activities, including assessment, causal factors, interventions, and education would be evaluated by the care plan team at the time of each comprehensive assessment. Each time a resident returned from a stay at another health care facility, a nurse would re-assess the resident to determine the risk for falls. The care plan would be reviewed and amended based on the re-assessment.

The facility failed to ensure R20's fall prevention of the wheelchair antiroll back device was in place on her wheelchair, placing the resident at risk for further falls.

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 _____	02/16/2023

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 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: The facility had a census of 32 residents. The sample included 14 residents, with six reviewed for side rails. Based on observation, record review, and interview, the facility failed to assess Resident (R)14, R 17, R1, R12, R21 and R20s' side rails for safe use. This deficient practice placed the six residents at risk for entrapment or injury. Findings included: - R14's diagnoses included dementia	F 700		

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 _____	02/16/2023

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 700	Continued From page 18	F 700		

(progressive mental disorder characterized by failing memory, confusion), hypertension (elevated blood pressure), cerebral vascular disease (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and hemiplegia (paralysis of one side of the body).

R14's "Quarterly Minimum Data Set" (MDS), dated 12/26/22, recorded R14 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The assessment revealed R14 required extensive staff assistance for bed mobility, transfer, dressing, and toilet use. The MDS lacked documentation the resident had bed side rails.

The "Activities of Daily Living (ADL) Care Plan," dated 2/15/23, recorded R14 required limited one staff assistance with bed mobility, transfers, locomotion, dressing, toileting, hygiene and eating. The "Care Plan" documented the resident preferred to have quarter rails on her bed to assist with repositioning.

R14's Electronic Medical Record (EMR) documented a side rail assessment, dated 1/13/23 indicated the resident had requested the quarter side rails while in bed.

On 2/14/22 at 09:00 PM, observation revealed an upper one-fourth side rail on the outer left side of the bed. The upper opening measured approximately 10 inches long by 3.5 inches wide on the bottom of the rail to the top of the mattress with the up and down opening 10 inches long by 3.5 inches wide. The side rails were positioned on both sides of the bed.

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 _____	02/16/2023

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 700	Continued From page 19	F 700		

On 02/14/23 at 9:00 AM Administrative Nurse D verified R14 had a "Side Rail Assessment," dated 01/13/23, that indicated the resident had requested quarter side rails for positioning.

On 02/14/23 at 10:30 AM, Administrative Staff A verified the rails on R14's bed had too large of openings for safety.

The "Bed Inspection" policy, dated 01/03/19, documented it is the policy of the facility to conduct regular inspections of bed frames, mattresses, and bed rails, as part of the regular maintenance program to identify areas of potential entrapment or other safety hazards. The community will ensure that bed rails, mattress, and bed frame are compatible. As an approach to provide a "safe, clean, comfortable, and homelike environment", maintenance program will include inspection of bed mattress to ensure they are clean and comfortable. The purpose of the policy is to comply with approaches to risk identification and prevention of entrapment or other relevant safety hazards. This will serve as a key component of care plan development including appropriate assessment of safety risk of each resident, implementation of appropriate interventions to reduce identified risk, monitoring of effectiveness of planned interventions and modifying interventions as indicated. It is the policy of the community to reduce entrapment and other safety hazards associated with resident bed rails, bed frames, mattresses, and other bed mobility devices.

The facility failed to adequately assess R14 for the appropriate side rail, placing him at risk for accident or injury.

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 _____	02/16/2023

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 700	Continued From page 20	F 700		

- R17's diagnoses included diabetic neuropathy (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin and causing pain and numbness in legs and feet), arteriosclerotic heart disease (ASHD-clogged arteries) and a history of transient ischemic attack (TIA- episode of cerebrovascular insufficiency).

R17's "Quarterly Minimum Data Set" (MDS), dated 01/04/23, recorded R17 had a Brief Interview for Mental Status (BIMS) score of 12, indicating mildly impaired cognition. The assessment revealed R17 required extensive staff assistance for bed mobility, personal hygiene, dressing and toilet use, and was total dependent on staff for transfers. The MDS lacked documentation the resident had bed side rails.

The "Activities of Daily Living (ADL) Care Plan," dated 01/16/23, recorded R17 required extensive two staff assistance with bed mobility, transfers, locomotion, dressing, toileting, and hygiene. The "Care Plan" lacked indication of the use of a side rail to assist with repositioning in bed.

R17's Electronic Medical Record lacked a side rail assessment.

On 02/13/23 at 03:05 PM, observation revealed R17 lying in bed on back watching TV. Continued observation revealed the resident had a quarter side rail attached to the left side of the bed closest to the door. Measurement of the opening of the cane rail was width three and three-quarters inches with the length approximately 12.5 inches from the top of the rail to the bar attached to the bed.

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 _____	02/16/2023

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 700	Continued From page 21	F 700		

On 02/14/23 at 9:00 AM Administrative Nurse D verified R17 lacked a "Side Rail Assessment."

On 02/14/23 at 10:30 AM, Administrative Staff A, verified the rails on R17's bed had too large of openings.

The "Bed Inspection) policy, dated 01/03/19, documented it is the policy of the facility to conduct regular inspections of bed frames, mattresses, and bed rails, as part of the regular maintenance program to identify areas of potential entrapment or other safety hazards. The community will ensure that bed rails, mattress, and bed frame are compatible. As an approach to provide a "safe, clean, comfortable, and homelike environment", maintenance program will include inspection of bed mattress to ensure they are clean and comfortable. The purpose of the policy is to comply with approaches to risk identification and prevention of entrapment or other relevant safety hazards. This will serve as a key component of care plan development including appropriate assessment of safety risk of each resident, implementation of appropriate interventions to reduce identified risk, monitoring of effectiveness of planned interventions and modifying interventions as indicated. It is the policy of the community to reduce entrapment and other safety hazards associated with resident bed rails, bed frames, mattresses, and other bed mobility devices.

The facility failed to adequately assess R17 for the appropriate side rail, placing him at risk for accident or injury.
- R1's Electronic Medical Record (EMR) documented a diagnosis of dementia (a group of

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 _____	02/16/2023

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 700	Continued From page 22	F 700		

conditions characterized by impairment of at least two brain functions, such as memory loss and judgment).

The "Quarterly Minimum Data Set" (MDS), dated 12/26/22, documented a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS documented R1 was independent with eating, required limited staff assistance for transfers, walking, toileting, dressing and extensive staff assistance for bed mobility. The MDS documented R1 had limited range of motion in one lower extremity, used a walker and a wheelchair, and had no falls since the prior MDS.

The "Care Plan," dated 12/26/22, lacked side rail information.

The "Fall Risk Assessment," dated 12/26/22, documented a score of 9 (10 or more represented a high risk).

On 02/14/23 at 10:30 AM, observation revealed side rails up on both sides of R1's bed with gaps of three inches by twelve inches wide.

On 02/14/23 at 10:30 AM, Administrative Staff A verified the gaps between the side rail bars were greater than 4.75 inches wide.

On 02/14/23 at 02:44 PM, Administrative Nurse D verified this resident did not have a side rail assessment. Administrative Nurse D stated staff assessed the residents who they expected to keep side rails on 01/13/23. She stated the facility was going to remove all other side rails at that time. Administrative Nurse D verified staff should have assessed the safety of the side rails for all

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 _____	02/16/2023

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 700	Continued From page 23	F 700		

residents which had them.

The facility's "Bed Inspection" policy, dated 01/03/2019, stated staff were to conduct regular inspections of bed rails to identify areas of potential entrapment or other safety hazards. The policy included the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006. Prior to admission staff would screen residents to determine if needs necessitated bed rails. Upon admission, change of condition, each resident would be screened to determine appropriate alternatives to bed rails, risk of entrapment prior to installation of bed rails, review the risks with the resident or their representative, and obtain informed consent. This will serve as a key component of care plan development including appropriate assessment of safety risk of each resident, implementation of appropriate interventions to reduce identified risk, monitoring of effectiveness of planned interventions and modifying interventions as indicated.

The facility failed to assess R1's bed side rails for safety, placing R1 at risk for entrapment and potential injury.

- R12's Electronic Medical Record (EMR) documented diagnoses of seizure disorder (disorder in which brain activity becomes abnormal, causing seizures or periods of unusual behavior, sensations and sometimes loss of awareness), cerebral palsy (group of disorders that affect a person's ability to move and maintain balance and posture), and history of a hip fracture.

The "Annual Minimum Data Set" (MDS), dated

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 _____	02/16/2023

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 700	Continued From page 24	F 700		

12/16/22, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R12 independent with eating, required extensive assistance of one staff for hygiene, and extensive assistance of two staff for bed mobility, transfers, dressing and toileting. The MDS documented R12 had limited range of motion (ROM) in one lower extremity, used a wheelchair, and had no falls since the prior MDS.

The "Care Plan," dated 02/14/23, directed staff to provide quarter rails on her bed for positioning. R12 had a BIMS of 15 and have been educated on the risk and benefits.

The facility lacked a "Side Rail Assessment" for this resident.

On 02/14/23 at 10:30 AM, observation revealed R12's bed with one side rail up and the gap between the bars was greater than 4.75 inches wide.

On 02/14/23 at 10:30 AM, Administrative Staff A verified the gaps between the side rail bars were greater than 4.75 inches wide.

On 02/14/23 at 02:44 PM, Administrative Nurse D verified this resident did not have a side rail assessment. Administrative Nurse D stated staff assessed the residents who they expected to keep side rails on 01/13/23. She stated the facility was going to remove all other side rails at that time. Administrative Nurse D verified staff should have assessed the safety of the side rails for all residents which had them.

The facility's "Bed Inspection" policy, dated

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 _____	02/16/2023

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 700	Continued From page 25	F 700		

01/03/2019, stated staff were to conduct regular inspections of bed rails to identify areas of potential entrapment or other safety hazards. The policy included the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006. Prior to admission staff would screen residents to determine if needs necessitated bed rails. Upon admission, change of condition, each resident would be screened to determine appropriate alternatives to bed rails, risk of entrapment prior to installation of bed rails, review the risks with the resident or their representative, and obtain informed consent. This will serve as a key component of care plan development including appropriate assessment of safety risk of each resident, implementation of appropriate interventions to reduce identified risk, monitoring of effectiveness of planned interventions and modifying interventions as indicated.

The facility failed to assess R12's bed side rails for safety, placing R12 at risk for entrapment and potential injury.

- R21's Electronic Medical Record (EMR) documented diagnoses of atrial-fibrillation (arrhythmia is when the heart beats too slowly, too fast, or in an irregular way), diabetes mellitus (group of diseases that affect how the body uses blood sugar), morbid obesity (serious health condition that results from an abnormally high body mass), and anxiety disorder (characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities).

The "Quarterly Minimum Data Set" (MDS), dated 12/16/22, documented a Brief Interview for

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 _____	02/16/2023

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 700	Continued From page 26	F 700		

Mental Status (BIMS) score of 12, indicating moderately impaired decision making. The MDS documented R21 was independent for eating, required limited staff assistance for dressing, and extensive staff assistance for bed mobility, transfers, and locomotion. The MDS documented R21 had impaired range of motion in both lower extremities.

The "Activities of Daily Living (ADL) Care Plan," dated 12/16/22, directed staff to provide one to two staff assistance with personal care, and transfer R21 with a total lift and two staff. The 01/04/23 care plan update directed rails on her bed for positioning. The care plan stated R21 had a BIMS of 14 and had been educated on the risk and benefits.

On 02/13/23 at 04:11 PM, observation revealed R21 in bed and side rails up on each side of the bed with 3.75 inch by 12-inch gaps.

The facility lacked a "Side Rail Assessment" for this resident.

On 02/14/23 at 10:30 AM, observation revealed R21's bed with two side rails up and the gap between the bars greater than 4.75 inches wide.

On 02/14/23 at 10:30 AM, Administrative Staff A verified the gaps between the side rail bars were greater than 4.75 inches wide.

On 02/14/23 at 02:44 PM, Administrative Nurse D verified this resident did not have a side rail assessment before 01/13/23, even though side rails had been used prior to that. Administrative Nurse D stated staff assessed the residents who they expected to keep side rails on 01/13/23.

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 _____	02/16/2023

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 700	Continued From page 27	F 700		

The facility's "Bed Inspection" policy, dated 01/03/2019, stated staff were to conduct regular inspections of bed rails to identify areas of potential entrapment or other safety hazards. The policy included the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006. Prior to admission staff would screen residents to determine if needs necessitated bed rails. Upon admission, change of condition, each resident would be screened to determine appropriate alternatives to bed rails, risk of entrapment prior to installation of bed rails, review the risks with the resident or their representative, and obtain informed consent. This will serve as a key component of care plan development including appropriate assessment of safety risk of each resident, implementation of appropriate interventions to reduce identified risk, monitoring of effectiveness of planned interventions and modifying interventions as indicated.

The facility failed to assess R21's bed side rails for safety, placing R21 at risk for entrapment and potential injury.

- R20's Electronic Medical Record (EMR) documented diagnoses of osteoporosis (medical condition in which the bones become brittle and fragile), anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), hypertension (high blood pressure), and insomnia (persistent problems falling and staying asleep.

The "Quarterly Minimum Data Set" (MDS), dated 12/30/22, documented a Brief Interview for

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 _____	02/16/2023

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 700	Continued From page 28	F 700		

Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented R20 was independent with eating, required limited staff assistance for locomotion, extensive assistance for bed mobility, transfers, dressing, toileting, and hygiene. The MDS documented R20 did not walk, had unsteady balance and used a wheelchair for mobility.

The "Care Plan," dated 12/26/22, lacked side rail information. The 01/14/23 update stated R20 preferred to have one quarter rails on her bed for positioning. She has been educated on the risk and benefits.

The "Cognition Care Plan" stated R20 alert and oriented with forgetfulness.

On 02/14/23 at 07:45 AM, observation revealed R20 in a low bed, mat in front of the bed, room door open, call light in reach, and one side rail up. The side rail had approximately 4.5 by 12-inch gaps between the bars.

On 02/14/23 at 10:30 AM, Administrative Staff A verified the gaps between the side rail bars were greater than 4.75 inches wide.

On 02/14/23 at 02:44 PM, Administrative Nurse D verified this resident did not have a side rail assessment before 01/13/23, even though side rails had been used prior to that. Administrative Nurse D stated staff assessed the residents who they expected to keep side rails on 01/13/23.

The facility's "Bed Inspection" policy, dated 01/03/2019, stated staff were to conduct regular inspections of bed rails to identify areas of potential entrapment or other safety hazards. The

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 _____	02/16/2023

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 700	Continued From page 29 policy included the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 03/10/2006. Prior to admission staff would screen residents to determine if needs necessitated bed rails. Upon admission, change of condition, each resident would be screened to determine appropriate alternatives to bed rails, risk of entrapment prior to installation of bed rails, review the risks with the resident or their representative, and obtain informed consent. This will serve as a key component of care plan development including appropriate assessment of safety risk of each resident, implementation of appropriate interventions to reduce identified risk, monitoring of effectiveness of planned interventions and modifying interventions as indicated. The facility failed to assess R20's bed side rails for safety, placing R20 at risk for entrapment and potential injury.	F 700		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		

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 _____	02/16/2023

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 756	Continued From page 30	F 756		

(d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 14 residents, with six reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to ensure the Consultant Pharmacist identified and reported to the Director of Nursing, facility medical director, and physician, the lack of a 14 day stop date for Resident (R)26's as needed (PRN) psychotropic (a medication that affects mood and/or thought) or rationale for use. This placed the resident at risk for inappropriate use of a psychotropic medication with side effects.

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 _____	02/16/2023

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 756	Continued From page 31	F 756		

Findings included:

- R26's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental, uncertainty and irrational fear), and depression (mood disorder characterized by persistent sadness).

R26's "Quarterly Minimum Data Set" (MDS), dated 01/29/23, documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. R26 required extensive assistance with bed mobility, transfer, dressing, toilet use, and locomotion on and off the unit and hygiene. The MDS documented R26 received an antianxiety and antidepressant medication for all seven of the look back days.

The "Psychosocial Care Area Assessment" (CAA), dated 02/03/23, documented R26 had a lack of interest with contributing factors which included depression and anxiety, and living in a facility for an extended time.

The "Behavior/Mood Care Plan," dated 11/22/22 recorded the staff would routinely observe the resident for changes in her mood and behavior related to psychotropic medication used including depression and anxiety. The care plan instructed the staff to provide the resident with emotional support, reassurance and redirection as needed.

The "Physician's Order," dated 11/23/22, directed the staff to administer Ativan (antianxiety) 2milligrams (mg) per milliliter (ml) administer 0.25 ml, oral concentrate, every four hours as needed for anxiety. The order lacked a stop date.

Review of the "Medication Administration Record"

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 _____	02/16/2023

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 756	Continued From page 32	F 756		

in the EMR revealed the resident last received the Ativan 0.25mg on 01/23/23 for anxiety.

R26's EMR lacked evidence of a physician rationale for continued use of the Ativan.

Review of the "Medication Regimen Reviews" on 11/28/22, 12/28/22, and 01/26/23 lacked evidence the Consultant Pharmacist identified the need for the as needed Ativan 14 day stop date.

On 02/15/23 at 12:10 PM, observation revealed the resident in a recliner in her room with a bedside table in front of her. She was eating lunch.

On 02/15/23 at 02:10 PM, Administrative Nurse D verified the resident received Ativan, with a physician order date of 11/23/22. Administrative Nurse D verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rational. Administrative Nurse D verified the Consultant Pharmacist failed to recommend a 14 day stop date for use of the residents as needed Ativan.

The "Antipsychotic Drugs" policy, undated, documented the facility would ensure the resident would not be given an antipsychotic medication unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the elder's clinical record. Any resident who receives an antipsychotic medication receives a gradual reduction , and behavioral interventions, unless clinical contraindicated, in an effort to discontinue these drugs to ensure the residents does not receive unnecessary medications and the lowest possible dose is administered for the shortest amount of

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 _____	02/16/2023

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 756	Continued From page 33	F 756		

time. The consulting pharmacist would review the appropriateness of all medication order for medication to be administered by clinical staff. The physician orders for antipsychotic medications ordered for emergency management of behaviors would have an automatic 72 hour stop date. Each resident who has an order for an antipsychotic medication would be assessed and periodically reassessed during their stay to determine the effectiveness of the medication. The staff would revise the care plan as indicated and report to the physician any findings that indicate a change in medication regimen may be indicated.

The "Consulting Pharmacist Services Provider Requirements" policy, undated, documented consult pharmacist services are provided to the residents. The consulting pharmacist provides pharmaceutical care services, include but not limited to the following; reviewing the medication regimen (drug regimen review) of each elder in health center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and findings in the elder's clinical record. Communicating potential or actual problems detected related to medication therapy orders to the responsible physician and the Director of Nursing. The pharmacist reviews MARS and physician orders monthly at the facility to ensure proper documentation of medication orders and administration of medication to elders.

The facility's Consultant Pharmacist failed to recommend to the facility Director of Nursing (DON), medical director, and physician the need for a 14 day stop date or rationale for continued use of PRN Ativan for R26. This placed the

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 _____	02/16/2023

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 756	Continued From page 34 resident at risk for inappropriate use of an as needed psychotropic medication with side effects.	F 756		
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 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	F 758		

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 _____	02/16/2023

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 758	Continued From page 35	F 758		

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 had a census of 32 residents. The sample included 17 residents, with six reviewed for unnecessary medications. Based on observations, interview and record review, the facility failed to ensure a 14- day stop date for Resident (R) 26 and R10 who received as needed (PRN) psychotropic (medication that affects mood and/or thoughts) medication that lacked a rationale for continued use. This placed the affected residents at risk for unintended affects related to psychotropic drug medications.

Findings included:

- R26's Electronic Medical Record (EMR) recorded diagnoses of anxiety (mental, uncertainty and irrational fear), and depression (mood disorder characterized by persistent sadness).

R26's "Quarterly Minimum Data Set" (MDS), dated 01/29/23, documented a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. R26 required

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 _____	02/16/2023

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 758	Continued From page 36	F 758		

extensive assistance with bed mobility, transfer, dressing, toilet use, and locomotion on and off the unit and hygiene. The MDS documented R26 received an antianxiety and antidepressant medication for all seven of the look back days.

The "Psychosocial Care Area Assessment" (CAA), dated 02/03/23, documented R26 had a lack of interest with contributing factors which included depression and anxiety, and living in a facility for an extended time.

The "Behavior/Mood Care Plan," dated 11/22/22 recorded the staff would routinely observe the resident for changes in her mood and behavior related to psychotropic medication used including depression and anxiety. The care plan instructed the staff to provide the resident with emotional support, reassurance and redirection as needed.

The "Physician's Order," dated 11/23/22, directed the staff to administer Ativan (antianxiety) 2milligrams (mg) per milliliter (ml) administer 0.25 ml, oral concentrate, every four hours as needed for anxiety. The order lacked a stop date.

Review of the "Medication Administration Record" in the EMR revealed the resident last received the Ativan 0.25mg on 01/23/23 for anxiety.

R26's EMR lacked evidence of a physician rationale for continued use of the Ativan.

On 02/15/23 at 12:10 PM, observation revealed the resident in a recliner in her room with a bedside table in front of her. She was eating lunch.

On 02/15/23 at 02:10 PM, Administrative Nurse D

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 _____	02/16/2023

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 758	Continued From page 37	F 758		

verified the resident received Ativan, with a physician order date of 11/23/22. Administrative Nurse D verified the facility failed to obtain the 14 days stop date or reason for continued use with the appropriate rational.

The "Antipsychotic Drugs" policy, undated, documented the facility would ensure the resident would not be given an antipsychotic medication unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the elder's clinical record. Any resident who receives an antipsychotic medication receives a gradual reduction , and behavioral interventions, unless clinical contraindicated, in an effort to discontinue these drugs to ensure the residents does not receive unnecessary medications and the lowest possible dose is administered for the shortest amount of time. The consulting pharmacist would review the appropriateness of all medication order for medication to be administered by clinical staff. The physician orders for antipsychotic medications ordered for emergency management of behaviors would have an automatic 72 hour stop date. Each resident who has an order for an antipsychotic medication would be assessed and periodically reassessed during their stay to determine the effectiveness of the medication. The staff would revise the care plan as indicated and report to the physician any findings that indicate a change in medication regimen may be indicated.

The facility failed to ensure R26 was free of the use of unnecessary psychotropic drugs when they failed to obtain a stop date for the use of PRN Ativan, placing R26 at risk for adverse effects from the continued use of those

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 _____	02/16/2023

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 758	Continued From page 38	F 758		

medications.

- R10's Electronic Medical Record (EMR) recorded diagnoses of acute respiratory distress, agoraphobia (extreme fear of entering crowded places, leaving one's home, or being in places from which escape is difficult) with panic disorder, anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder, cachexia (weakness and wasting of body due to severe chronic illness), chronic kidney disease, chronic obstructive pulmonary disease (COPD- progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) with exacerbation, dependence on supplemental oxygen, major depressive (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) disorder, memory deficit following other cerebrovascular (any abnormal condition characterized by dysfunction of the heart and blood vessels) disease, dementia (progressive mental disorder characterized by failing memory, confusion), pain, psychotic (any major mental disorder characterized by a gross impairment in reality testing) disturbance, 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) and thrombosis (clot that developed within a blood vessel) of unspecified deep veins of right lower extremity.

The "Significant Change Minimum Data Set" (MDS), dated 01/13/23, documented R10 had severe cognitive impairment, had inattention and

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 _____	02/16/2023

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 758	Continued From page 39	F 758		

disorganized thinking behaviors which fluctuated, required limited assistance of one staff for activities of daily living (ADLs), was not steady and only able to stabilize with staff assistance and used a wheelchair for mobility, and occasional incontinence of urine. The MDS further documented R10 had dementia, anxiety, depression, no pain management, had shortness of breath with exertion, had a condition or chronic disease that may result in a life expectancy of less than six months, and had not fallen since prior assessment. R10 had received an antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), anticoagulant (preventing blood from clotting) and diuretic (increased formation and secretion of urine) daily, used oxygen and hospice care (care provided for terminal illness/condition).

The "Psychotropic Medication Use Care Area Assessment" (CAA), dated 01/20/23, documented the use of psychotropic (medication which affects how the brain works and causes changes in mood, awareness, thoughts, feeling, or behavior) medication to manage psychiatric illness/condition and a licensed nurse monitored for side effects and physician to be notified of any abnormal findings. A pharmacist consultant will review mediations monthly and the physician will review medications with each visit. The CAA further documented risk factors included increased falls, impaired balance, and potential for adverse effects of medication and the care plan would be coordinated with hospice to maintain comfort and dignity throughout the end of life process as it relates to effectiveness of psychotropic medication and adverse effects of medication.

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 _____	02/16/2023

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 758	Continued From page 40	F 758		

The "Antipsychotic Care Plan' dated 01/23/23 recorded the use of haloperidol (antipsychotic). Report any changes in level of consciousness to the doctor, monitor for side effects of antipsychotic medication regimen and notify physician as indicated. The care plan directed staff to obtain an "Abnormal Involuntary Movement Scale "(AIMS) assessment quarterly and as needed (PRN). The care plan documented a signed consent for psychoactive medication will be in attachments and discussed annually and PRN.

The "Progress Note", dated 01/05/23 at 06:03 PM, documented R10 was hollering for help. The nurse asked what she needed and R10 yelled "I need help into bed". The note further documented R10 appeared restless and the physician was contacted. The physician ordered staff to give lorazepam (antianxiety medication) 0.25 milligrams (mg) orally then, and if not effective, give 0.25 mg again.

On 01/16/23 the "Physician Order" directed haloperidol 0.5 mg tablet for nausea. The order further instructed to give sublingual (under tongue), oral, or per rectum, and may increase dose up to two mg every four hours if starting dose was ineffective. The order lacked a stop date.

On 01/14/23 the "Physician Order" directed lorazepam 0.5 mgs to give sublingual or oral every hour prn for anxiety/restlessness. The order lacked a stop date.

On 02/14/23 at 02:56 PM observation revealed R10 in bed, which was low to the ground. There

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	175124	A. BUILDING _____ B. WING _____	02/16/2023

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

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F 758	Continued From page 41 was a mat next to the bed. R10 had oxygen by nasal cannula, her eyes were closed. The head of the bed was slightly elevated. R10 was holding a water cup in her hand. On 02/15/23 at 10:03 AM, Administrative Nurse G stated she was not aware of the haloperidol order and stated the hospice services obtained the lorazepam order. Administrative Nurse G verified both haloperidol prn and lorazepam prn did not have stop dates. The facility's undated "Antipsychotic Drug" policy documented based on a comprehensive assessment of each elder, the interdisciplinary team will ensure an elder who has not used antipsychotic drug unless antipsychotic drug therapy was necessary to treat a specific condition as diagnosed and documented in the elder's clinical record. All physician orders for antipsychotic medications ordered for emergency management of behaviors will have an automatic 72 hour stop date. Each elder who has an order for antipsychotic drug will be assessed and periodically reassessed during their residency to determine the effectiveness of the medication. The facility failed to ensure R10 as needed haloperidol and lorazepam had a stop date as required, or a physician documented rationale for continued use for the lorazepam, which placed the resident at risk for adverse side effects related to psychotropic medication.	F 758		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		

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F 883	Continued From page 42 §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative	F 883		

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F 883	Continued From page 43	F 883		

has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 32 residents. The sample included 14 residents of which five were reviewed for immunization status. Based on record review and interview, the facility failed to offer and provide the residents and/or their representative the current years Influenza "Vaccine Information Statement" (VIS-informed sheets produced by the CDC [Centers for Disease Control and Prevention] that explained both the benefits and risk of vaccine to vaccine recipients for Resident (R)4, R12, R17, R20 and R25. This placed the affected residents at increased risk for illness and infection.

Findings included:

- R4's clinical record lacked evidence the current year Influenza "Vaccine Information Statement" form was provided to the resident and/or resident's representative, or an informed refusal was obtained.

R12's clinical record lacked evidence the current year Influenza "Vaccine Information Statement" form was provided to the resident and/or

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F 883	Continued From page 44	F 883		

resident's representative or an informed refusal was obtained.

R17's clinical record lacked evidence the current year Influenza "Vaccine Information Statement" form was provided to the resident and/or resident's representative or an informed refusal was obtained.

R20's clinical record lacked evidence the current year Influenza "Vaccine Information Statement" form was provided to the resident and/or resident's representative or an informed refusal was obtained.

R25's clinical record lacked evidence the current year Influenza "Vaccine Information Statement" form was provided to the resident and/or resident's representative or an informed refusal was obtained.

On 02/14/23 at 03:10 PM Administrative Nurse F verified the residents were offered the yearly influenza vaccine, but the facility failed to provide the current year CDC "Vaccine Information Statement" and failed to obtain a yearly signed consent from the resident and/or their representative.

The "Influenza and Pneumonia " policy, undated, documented all residents, staff and volunteers of the facility would be offered the influenza vaccine annually unless contraindication or the resident or representative refuses the vaccine after appropriate education related to the risk of the conditions and the risk of failure to receive the vaccines. The vaccines would be administered by any appropriate qualified personnel who are followed facility procedures, without the need for

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F 883	Continued From page 45 an individual physician evaluation or order other than the signed standing order. Each person offered the vaccine(s) would be provided the current information from Centers for Disease Control and Federal Drug Administration regarding benefits and risk of the vaccine. The policy documented prior to offering the influenza or pneumovax, each representative and their representative would receive current information regarding the benefits and potential side effects of the immunization. Informed consent in the form of a discussion regarding risk, benefits and potential side effects of the vaccination would occur prior to the vaccination. The facility failed to offer and provide and/or obtain informed refusals for influenza vaccinations for R4, R12, R17, 20 and R25 and failed to provide the current year VIS. This placed the affected residents increased risk for illness and infection.	F 883		