STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175210	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - PARSONS	709 LEAWOOD AVENUE PARSONS, KS 67357

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 15 sampled for review. Based on observation, interview, and record review, the facility failed to develop and implement a plan of care for respiratory cares related to oxygen use for one sampled Resident (R) 27. Findings Included: - Review of Resident (R)27's Physician Orders, dated 01/20/2020, documentation included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], documentation included the resident rarely/never understands and was not able to complete the Brief Interview for Mental Status. He had short- and long-term memory problems and with severely impaired decision-making skills. The MDS lacked documentation of oxygen usage. The quarterly MDS, dated [DATE], lacked documentation of oxygen usage. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 05/14/2019, did not trigger and lacked documentation related to oxygen use. The care plan (CP), dated 02/12/2020, did not address the use of oxygen for the resident. The Physician order [REDACTED]. Call the provider/practitioner with nursing report, as needed for dyspnea (difficulty breathing), [MEDICAL CONDITION] (abnormal deficiency in the concentration of oxygen), or acute [MEDICAL CONDITION], ordered 10/09/2019. The Vitals Tab of the electronic medical record (EMR), documented the most recent oxygen saturation, dated 02/07/2020, as 96 %, on room air. Additionally, the most recent oxygen saturation below 90%, documented on 12/12/2019, as 88.0 % on room air. The EMR lacked documentation of monitoring of oxygen saturation levels to determine the necessity or effectiveness of the use of the oxygen. On 03/09/20 at 10:02 AM, the resident received oxygen at three liters per minute by way of nasal cannula. The humidifier bottle and tubing were not marked to reflect the date of the most recent change of the tubing and humidifier bottle. On 03/10/2020 at 04:32 PM, the humidifier bottle was almost empty and lacked water to cover the internal tube that humidified the air to the nasal cannula. The resident pulled the nasal cannula from his nose and left it across his forehead. On 03/10/2020 at 04:47 PM, Licensed Nurse (LN) H verified the humidifier bottle was almost empty and the resident with the tubing pulled out from his nose and positioned on his forehead. He reported the humidifier bottle and tubing should be changed every week and labeled with the date. LN H verified he did not make rounds to check tubing or humidifier bottles that he depended on the aides to inform him. On inquiry he stated no one had reported that the resident's humidifier bottle was empty or the tubing was not labeled appropriately. On 03/09/20 at 11:32 AM, the resident's spouse reported the resident used oxygen all the time and it dried his nasal passages. On 03/11/2020 at 09:49 AM, Certified Nurse Aide (CNA) M reported the care plan provided guidance for the resident's care. He received oxygen continuously and staff should check for placement of the tubing to keep it off the floor and that it remained covered when not in use. She stated the humidifier bottle should be checked to make sure there was water present to prevent the resident's nose from drying out. CNA M reported the night shift nurse changed out the oxygen tubing and humidifier bottles every week and should write the date when she changed the tubing and humidifier bottle. The charge nurses should monitor the oxygen equipment, fill the humidifier bottles with water, and monitor the resident's oxygen saturation to determine the need for oxygen. On 03/11/2020 at 02:09 PM, LN I stated the care plan provided guidance regarding the resident's individual needs and preferences. She reported the staff should monitor for effectiveness of the oxygen usage. She reported the resident used continuous oxygen for the last couple of months. LN I stated she personally checked the oxygen saturation periodically and documented it in the EMR. She stated if the resident took the oxygen off, his oxygen saturations would drop to 80%. She verified the most recent documentation of the resident's oxygen saturation levels were 02/07/2020, and her most recent documentation was 10/2019. LN I agreed the staff did not monitor the residents use of oxygen appropriately. She verified the EMR lacked documentation the night staff changed the oxygen tubing and humidifier bottle weekly. LN I stated she did not remember checking the oxygen equipment and/or effectiveness. On 03/11/2020 at 03:24 PM, CNA N reported the care plan should guide the staff on the care associated with the resident's oxygen use. She reported the resident used oxygen all the time since he started using it. The staff should check the liter flow, water in the humidifier bottle, and if there were any problems the staff should let the charge nurse know. CNA N stated she was not sure what the resident's status was, that one nurse would say the resident needed it all the time while the other nurse would say the resident used it prn. CNA N stated she had not seen the nurses checking the resident's oxygen saturation or fill the humidifier bottle. On 03/11/2020 at 03:47 PM, LN J reported the resident admitted with a as needed (prn) order for oxygen and he would use the oxygen when the resident's oxygen saturations dropped below 90%. The resident used oxygen for at least the last three to four weeks. Nurses should check for water levels in the humidifier bottles to prevent the resident's nasal passages from drying. LN J stated the oxygen saturations were documented in the Vitals Tab of the EMR. On 03/12/2020 at 08:22 AM, Administrative Nurse E confirmed the oxygen order as noted above. She verified the care plan lacked guidance for the staff related to the use of oxygen for the resident. Administrative Nurse E stated the staff should monitor the resident's oxygen saturations to determine the need for oxygen and the effectiveness. The staff should document the oxygen saturation in the EMR. She agreed the staff did fail to monitor the resident's oxygen use and provide care as she would expect. The facility policy Care Plan, dated 12/2019, documentation included the plan of care will be modified to reflect the care currently required/provided for the resident. The facility failed to develop and implement a plan of care for respiratory care related to oxygen use for the resident.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents with 15 residents sampled which included four residents sampled for respiratory care. Based on observation, interview and record review the facility failed to ensure that residents who needed respiratory care received such care consistent with professional standards of practice for two Residents (R)27 and R 11 associated with the use of oxygen. Findings Included: - Review of Resident (R)27's Physician Orders, dated 01/20/2020, documentation included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], documentation included the resident rarely/never understands and was not able to complete the Brief Interview for Mental Status. He had short- and long-term memory problems and with severely impaired decision-making skills. The MDS lacked documentation of oxygen usage. The quarterly MDS, dated [DATE], lacked documentation of oxygen usage. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 05/14/2019, did not trigger and lacked documentation related to oxygen use. The care plan (CP), dated 02/12/2020, did not address the use of oxygen for the resident. The Physician order [REDACTED]. Call the provider/practitioner with nursing report, as needed for dyspnea (difficulty breathing), [MEDICAL CONDITION] (abnormal deficiency in the concentration of oxygen), or acute [MEDICAL CONDITION], ordered 10/09/2019. The Vitals Tab of the electronic medical record (EMR), documented the most recent oxygen saturation, dated 02/07/2020, as 96 %, on room air. Additionally, the most recent oxygen saturation below 90%, documented on 12/12/2019, as 88.0 % on room air. The EMR lacked

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) documentation of monitoring of oxygen saturation levels to determine the necessity or effectiveness of the use of the oxygen. On 03/09/20 at 10:02 AM, the resident received oxygen at three liters per minute by way of nasal cannula. The humidifier bottle and tubing were not marked to reflect the date of the most recent change of the tubing and humidifier bottle. On 03/10/2020 at 04:32 PM, the humidifier bottle was almost empty and lacked water to cover the internal tube that humidified the air to the nasal cannula. The resident pulled the nasal cannula from his nose and left it across his forehead. On 03/10/2020 at 04:47 PM, Licensed Nurse (LN) H verified the humidifier bottle was almost empty and the resident with the tubing pulled out from his nose and positioned on his forehead. He reported the humidifier bottle and tubing should be changed every week and labeled with the date. LN H verified he did not make rounds to check tubing or humidifier bottles that he depended on the aides to inform him. On inquiry he stated no one had reported that the resident's humidifier bottle was empty or tubing was not labeled appropriately. On 03/09/20 at 11:32 AM, the resident's spouse reported the resident used oxygen all the time and it dried his nasal passages. On 03/11/2020 at 09:49 AM, Certified Nurse Aide (CNA) M reported the care plan provided guidance for the resident's care. He received oxygen continuously and staff should check for placement of the tubing to keep it off the floor and that it remained covered when not in use. She stated the humidifier bottle should be checked to make sure there was water present to prevent the resident's nose from drying out. CNA M reported the night shift nurse changed out the oxygen tubing and humidifier bottles every week and should write the date when she changed the tubing and humidifier bottle. The charge nurses should monitor the oxygen equipment, fill the humidifier bottles with water, and monitor the resident's oxygen saturation to determine the need for oxygen. On 03/11/2020 at 02:09 PM, LN I stated the care plan provided guidance regarding the resident's individual needs and preferences. She reported the staff should monitor for effectiveness of the oxygen usage. She reported the resident used continuous oxygen for the last couple of months. LN I stated she personally checked the oxygen saturation periodically and documented it in the EMR. She stated if the resident took the oxygen off, his oxygen saturations would drop to 80%. She verified the most recent documentation of the resident's oxygen saturation levels were 02/07/2020, and her most recent documentation was 10/2019. LN I agreed the staff did not monitor the residents use of oxygen appropriately. She verified the EMR lacked documentation the night staff changed the oxygen tubing and humidifier bottle weekly. LN I stated she did not remember checking the oxygen equipment and/or effectiveness. On 03/11/2020 at 03:24 PM, CNA N reported the care plan should guide the staff on the care associated with the resident's oxygen use. She reported the resident used oxygen all the time since he started using it. The staff should check the liter flow, water in the humidifier bottle, and if there were any problems the staff should let the charge nurse know. CNA N stated she was not sure what the resident's status was, that one nurse would say the resident needed it all the time while the other nurse would say the resident used it prn. CNA N stated she had not seen the nurses checking the resident's oxygen saturation or fill the humidifier bottle. On 03/11/2020 at 03:47 PM, LN J reported the resident admitted with a as needed (prn) order for oxygen and he would use the oxygen when the resident's oxygen saturations dropped below 90%. The resident used oxygen for at least the last three to four weeks. Nurses should check for water levels in the humidifier bottles to prevent the resident's nasal passages from drying. LN J stated the oxygen saturations were documented in the Vitals Tab of the EMR. On 03/12/2020 at 08:22 AM, Administrative Nurse E confirmed the oxygen order as noted above. She verified the care plan lacked guidance for the staff related to the use of oxygen for the resident. Administrative Nurse E stated the staff should monitor the resident's oxygen saturations to determine the need for oxygen and the effectiveness. The staff should document the oxygen saturation in the EMR. She agreed the staff did fail to monitor the resident's oxygen use and provide care as she would expect. The facility policy for Oxygen Administration with Nasal Cannula, dated 10/2017, documentation included fill humidifier bottle, with distilled water and keep filled adequately at all times. Assess resident for at least 15 to 30 minutes after beginning of therapy and at regular intervals depending on the resident's condition. Disposable equipment should be changed weekly or according to manufacturer's instructions and marked with date and initials when changes. The facility failed to ensure the resident who needed respiratory care received such care consistent with professional standards of practice related to the monitoring for the need and effectiveness of oxygen therapy. - The Medication Review Report, dated 01/07/2020, for Resident (R)11, included [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), dated [DATE], assessed R11 as having a Brief Interview of Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. R11 did not have any shortness of breath, fever, or use of oxygen, and his pneumonia vaccine was up to date. Did not receive any respiratory therapy or antibiotic medication. The significant change MDS, dated [DATE], assessed R11 with a BIMS score of 9, shortness of breath with exertion, and he used oxygen. He was not on an antibiotic, did not receive respiratory services, and his pneumonia vaccine was up to date. The care plan, dated 12/14/19, included a new problem, dated 02/21/2020, that R11 had a PRN (as needed) order for oxygen therapy related to [MEDICAL CONDITION]. R11 was to receive oxygen therapy at one to four liters per minute per nasal cannula for dyspnea (difficulty breathing), [MEDICAL CONDITION] (inadequate supply of oxygen), acute [MEDICAL CONDITION] (chest pain), and oxygen saturations less than 88%. Furthermore, the care plan included a new problem added on 02/28/2020, that R11 had a respiratory infection. The resident had a new physician order, on 03/07/2020 for [MEDICATION NAME] (an antibiotic) due to pneumonia, and on 03/08/2020 for [MEDICATION NAME] (medication delivered by inhalation per a nebulizer machine-a device which changes liquid medication into a mist easily inhaled into the lungs). On 03/10/2020 at 10:29 AM, the oxygen tubing lacked a date staff changed it, the nebulizer mask kit lacked a date staff changed it, and the nebulizer mask kit remained connected together and hanging from the strap that connected to the mask from the nebulizer machine. On 03/11/2020 at 08:48 AM, R11's oxygen tubing remained connected to the oxygen concentrator was laying on the floor, undated. The nebulizer kit remained connected and laying on top of the bedside stand, undated, and with a small amount of clear liquid in the bottom of the medicine cup, and the mask contained visible smears on it. On 03/11/2020 at 09:17 AM, R11 was sitting in the recliner in his room with the oxygen cannula in place to his nose, and with the tubing undated. On 03/11/2020 at 11:13 AM, Licensed Nurse (LN) G, placed [MEDICATION NAME] into the medicine cup of the undated, connected, nebulizer kit and placed the mask on R11's face. When the treatment completed, LN G removed the mask and disconnected the tubing from the medicine cup, rinsed the pieces to the nebulizer kit with hot water, then placed the pieces of the nebulizer kit on a paper towel near the nebulizer machine. On 03/11/2020 at 11:37 AM, LN G revealed that the kit remained connected when she entered the room because the previous nurse did not take it apart after the treatment was done this morning. When staff cleaned the kit it was to air dry, and then be placed in a container. The staff changed the kit weekly on Thursdays along with the oxygen tubing. Furthermore, she revealed that she would date the tubing and the kit if she changed them, but the night shift nurse says the tubing did not have to be dated anymore, and that the oxygen nasal cannula that inserted into the resident's nose should not be on the floor and the tubing should be stored in a plastic bag on the side of the concentrator when not in use. On 03/11/2020 at 03:36 PM. Administrative Nurse D, confirmed that oxygen tubing should be stored in a bag to protect it when not in use and should not be on the floor. The bag should be attached to the concentrator. The tubing was changed weekly, it was to be signed out on the TAR (treatment administration record), and she did not believe it was a policy to date the tubing. Furthermore, she revealed that the nebulizer kits should be stored open to air after cleansing with soap and water. The oxygen tubing and nebulizer kits are changed out weekly. The facility policy for, Nebulizer procedure, revised 03/18, instructed staff that following medication administration staff were to rinse the equipment with hot water and place it on a paper towel to air dry. The facility policy for, Oxygen Administration with Nasal Cannula, Face Mask, or Face Tent procedure, revised 10/17, instructed when oxygen was not in use, store the cannula in a plastic bag secured to the oxygen concentrator. Furthermore, it instructed that disposable equipment should be changed weekly or according to the manufacturer's instruction and marked with the date and the staff's initials. The facility failed to store the resident's oxygen tubing in a plastic bag when not in use, failed to date the tubing of the oxygen and nebulizer kit when changed, and failed to clean and store the nebulizer kit per facility procedure, to prevent further respiratory infections for the resident.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** The facility reported a census of 50 residents. Based on observation and interview, the facility failed to store, prepare, and serve food under sanitary conditions to the residents of the facility. Findings included: - During the initial tour

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) of the dietary department, on 03/09/2020 at 09:27 AM, revealed the following area/items of concern: 1. The air vents, over the food prep area and over the stove, in the ceiling had rust and were dusty. 2. The ceiling tiles, over the food prep area, had a thick layer of dust. 3. The white wooden cabinets, throughout the kitchen, had peeling paint, which exposed bare wood that is an unsanitizable surface. 4. There was brown sticky substances on the back of the stove/grille. 5. There is a sticky, greasy build-up on the handle of the oven. 6. The inside of the microwave had peeling paint, revealing metal. On 03/09/2020 at 09:45 AM, dietary staff BB verified the above areas requiring cleaning. The facility policy, dated 04/2016, Kitchen Cleaning Routine, documented to properly and thoroughly clean the kitchen and dining areas. Procedure-The following cleaning must be done with the indicated frequency . The facility failed to store, prepare, distribute, and serve food under sanitary conditions for the residents of the facility.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 50 residents. Based on observation, record review, and interview the facility failed to maintain an effective infection control program when the facility failed to use appropriate hand hygiene during a wound treatment for [REDACTED]. Finding included: - The tour of the laundry area conducted, on 03/12/2020 at 11:06 AM, with Housekeeping/Laundry Supervisor U revealed infection control concerns which included: 1. There was a thick dust build up on the vents over the washing machines and in the dryer area. 2. The filter on the large washing machine contained a buildup of lent and dust. On 03/12/2020 at 11:30 AM, Housekeeping/Laundry Supervisor U confirmed the above findings related to the surfaces in the laundry processing area to prevent cross contamination. The facility policy for, Procedure for Laundry Room, dated 03/2016, documentation included, Due to the bio-load introduced into the soiled room/area and the necessity to maintain the clean laundry room/area to preserve the cleanliness of the laundered material, it is crucial that frequent cleaning, disinfecting, and inspections of the laundry room occur. All surfaces should be damp dusted with a disinfectant cleaner at least weekly. The facility failed to ensure the proper handling, storage, and processing of laundry to prevent the spread of infection and cross contamination for the residents of the facility. - The Physician Orders, dated 03/09/2020, for Resident (R)50, included an order for [REDACTED]. Then, with gloved hands, LN G knocked on R50's door, moved a table away that was in front of her, unplugged the intravenous medication pump from the wall, moved the pole that the pump was on closer to R50. With the same (now contaminated) gloved hands, LN G then cleaned the intravenous access site with an alcohol wipe, flushed the access site, spiked the bag of medication, primed the intravenous medication tubing, setup the intravenous pump, connected the tubing to the access site, then removed the contaminated gloves and sanitized her hands. On 03/11/2020 at 11:53 AM, LN G verified that the gloves should have been removed, hand hygiene performed, and new gloves applied before cleaning and accessing the intravenous site, after she had entered the room and touched multiple objects with the same gloved hands. On 03/11/20 at 03:49 PM, Administrative Nurse D, confirmed LN G should have removed the gloves, performed hand hygiene, and applied new gloves after touching multiple objects in the room of R50 before accessing the intravenous site. The facility policy for, Contact Precautions procedure, revised 12/19, instructed the staff to don gloves upon entry into the room, and to change gloves and wash hands after contact with material that could contain high concentrations of microorganisms. The facility failed to remove contaminated gloves, perform hand hygiene, and apply new gloves after touching multiple objects before accessing the intravenous site of R50, to reduce the transmission of infection to this resident.