STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E294	A. BUILDING _____ B. WING _____	09/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
F W HUSTON MEDICAL CENTER	408 DELAWARE STREET WINCHESTER, KS 66097

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 34 residents. The sample included 13 residents. Based on observation, interview, and record review the facility failed to review and revise the comprehensive care plan for Resident (R) 9, admitted to hospice care. Findings include: - R9's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Quarterly ((MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R9 required limited assistance of one or two staff members with bathing and dressing and limited assistance of one staff member for bed mobility, transfer, toilet use and personal hygiene. The Care Plan revised on 07/16/20, lacked instruction to staff for R9's hospice care including frequency of visits, equipment provided, medications covered and hospice contact numbers. The Hospice Communication dated 08/21/20, documented admission to hospice. The Hospice Communication dated 09/01/20, documented R9 slept but woke up. She was tired this morning, and denied pain. On 09/02/20 at 07:16 AM, observation revealed R9 laid supine (on back face upwards) in bed, blankets covered torso, eyes closed, staff at bedside obtained vital signs and completed assessment. On 09/02/20 at 01:45 PM, Certified Nursing Assistant (CNA) M stated bathing was done by facility staff at this time. CNA M stated she was unsure when hospice CNA was scheduled to visit. On 09/03/20 at 12:25 PM, Administrative Nurse D stated she expected an integrated care management plan between R9's hospice program and the comprehensive plan of care. The facility's Care Planning Process policy, dated 06/20, documented the care plan would be review and revised when treatment plans are added, removed or revised based on the resident's condition. The facility failed to review and revise R9's care plan on admission to hospice, placing her at risk for inconsistent care.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 13 residents. Based on interviews and record review the facility failed to document a recapitulation of the facility stay, upon discharge from the facility, for Resident (R) 33, sampled for discharge. Findings included: - The [DIAGNOSES REDACTED]. R33's Admission Minimum (MDS) data set [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. She was independent with her Activities of Daily Living (ADLs). An active discharge plan, to return to the community, was in place. The ADL Functional/Rehabilitation Potential Care Area assessment dated [DATE] documented R33 participated in physical and occupational therapy. She desired to become strong enough to return home. She demonstrated unsteadiness during transfers and ambulation. R33 used a walker for support. The Care Plan dated 05/27/20 documented R33's goal was to remain in the facility until she was safe to return home. The facility included her family with her discharge plans. The Discharge Summary Note dated 08/07/20 documented the facility staff discussed discharge instructions with R33 and her spouse. She was accompanied by her spouse, upon discharge to home. The form lacked a full recapitulation of R33's stay. On 09/03/20 at 10:39 AM Licensed Nurse G stated discharge instructions were reviewed with the resident and family prior to discharge. The residents were discharged with the instructions, medications, and their belongings. LN G did not know what a recapitulation of a resident's stay was. On 09/03/20 at 12:00 PM Administrative Nurse (AN) D stated residents were sent home with a medication list and discharge instructions. The discharge notes documented the instructions given to the resident, how the resident discharged to home, and with whom he/she discharged with. AN D did not believe there was a recapitulation of stay for R33. The facility's Transfer or Discharge of a Resident policy dated June 2020 lacked documentation for the recapitulation of the residents' stay. The facility failed to document a recapitulation of R33's facility stay after her discharge from the facility.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 34 residents. The sample included 13 residents. Based on observations, record reviews, and interviews the facility failed to provide an appropriate end date for two as needed (PRN) antipsychotic medications (class of medications use to treat [MEDICAL CONDITION]-(any major mental disorder characterized by a gross impairment in reality testing- and other mental emotional conditions) for Resident (R) 18, one of five sampled residents for medication review. Findings included: - R18's electronic medical record (EMR) documented [DIAGNOSES REDACTED]. The Admission Minimum Data Set ((MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 00, which indicated severely impaired cognition. The MDS documented R18 required limited extensive assistance of one to two staff for dressing and bathing, limited assistance of one staff for toilet use, bed mobility, transfer and personal hygiene. The MDS documented R18 received antipsychotic medications, antidepressants (class of medications use to treat mood disorders and relieve symptoms of exaggerated feelings of sadness, worthlessness and emptiness), and antianxiety medications(class of medications that calm and relax people with excessive nervousness or tension), seven of seven days during the look back period. The [MEDICAL CONDITION] Drug Use Care Area Assessment (CAA) date 07/02/20, documented R18 was administered his psychoactive medications (affecting the mind) per physicians' orders. Monitoring of effectiveness (behaviors) and for side effects occurred by licensed nurses each shift and his physician kept abreast of changes in behaviors and adjustments made. The Care Plan revised on 07/14/20, documented R18 received antipsychotic medications that required monitoring for side effects and applicability (relevant or appropriate). The care plan documented R18 received medications for dementia and behaviors, administered them as ordered, and monitored and reported any adverse reactions (undesired or harmful effect from a medication) to the physician. The Order tab dated 08/16/20, documented the order for [MEDICATION NAME] (antipsychotic medication) 25 milligrams (mgs.) by mouth as needed (prn) for agitation and aggressive behavior related to dementia with behavioral disturbances, may have an extra dose one time daily. The order lacked an end date. On 09/03/20 at 09:28 AM,

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 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Licensed Nurse (LN) G confirmed the lack of end date for the prn medication. On 09/03/20 at 12:25 PM, Administrative Nurse D verified prn antipsychotic medications should contain an end date per drug guidelines. The facility's Psychoactive Drug policy, dated 06/20, documented the facility would monitor [MEDICAL CONDITION] medications. The policy further stated PRN antipsychotic drugs would be limited to 14 days. The facility failed to provide an appropriate end date for one as needed (PRN) antipsychotic medications for Resident (R) 18, placing the resident at risk for adverse side effects.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 34 residents. The sample included one medication room and two medication carts. Based on observations, record reviews, and interviews, the facility failed to properly label, and store physician prescribed medications. Findings included: - On 09/01/20 at 08:00 AM the facility's medication cart number one contained a Breo inhaler (medication used to treat respiratory conditions, shortness of breath) opened and undated. A review of the manufacturer's instructions for the Breo inhaler at www.mybreo.com revealed the inhaler should be discarded six months after opening the foil tray or when the counter reached zero, whichever came first. On 09/01/20 at 08:20 AM medication number two contained a [MEDICATION NAME] Pen (medication used to treat diabetes mellitus-when the body can't use glucose, not enough insulin is made, or the body can't respond to the insulin) with an open date of 07/07/20 and an expiration date of 08/05/20 and a bottle of [MEDICATION NAME] solution (medication used to remove wax buildup in ears) with an expiration date of 08/17/20. On 09/01/20 at 08:15 AM Licensed Nurse (LN) I stated inhalers were dated when opened but, did not see a date on the Breo inhaler. On 09/03/20 at 10:49 AM LN G stated expired medications had the potential of treatment actions. On 09/03/20 at 12:00 PM Administrative Nurse D stated insulins and inhalers are dated when opened. Administration of expired medications had the potential of ineffective treatment actions. The facility's Medication Administration policy dated June 2020 documented medication were administered to the residents as ordered, and in a safe and timely manner. The facility failed to properly label and store three medications, which placed the residents at risk for adverse physical consequences and/or ineffective treatments.
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 34 residents. Based on observation, record review, and interview the facility failed to store, prepare, and serve food under sanitary conditions for 34 residents of the facility who received food prepared in one of one facility kitchen. Findings included: - On 09/01/20 at 08:07 AM, during initial tour of the kitchen, observation revealed the following: Two areas of peeling paint above the three-compartment sink Dried food particles on the floor between stove and two-door oven Dried food crumbles on multiple flat surfaces of the prep table and stainless-steel cart Multiple dried areas of yellow oil-type substance on the two-compartment deep fryer Hand tongs laid in approximately eight inches by four inches puddle of yellow liquid on the lid of one deep fryer station. Four floor tiles missing from the restroom used by kitchen employees, stacked below the restroom sink. One uncovered square trash container, full of paper trash, adjacent to the prep table workstation. On 09/02/20 at 10:35 AM, observation revealed: One large soiled rag laid on the floor next to the steam table Paper towels on the floor seen through open bathroom door, used by the kitchen employees Multiple areas of dried food on the six-burner gas stove The Daily Chores Schedule date 08/2020, documented clean fryer, clean stove and pull burners initialed on 08/31/20 The Monthly Chore Schedule dated 08/2020, documented the stove cleaned 08/01/20. The Monthly Chore Schedule documented wipe down all carts in department, including garbage cart, clean all shelves and legs of carts, plate and saucer shelf, and remove all dishes from shelves twice monthly, lacked signature. On 09/02/20 at 10: 45 AM, Dietary Manager (DM) BB verified the areas of concern in the kitchen area and stated a repair request had been submitted to the plant supervisor the previous month. On 09/02/20 at 02:04 PM, Maintenance Supervisor U confirmed the missing tile area in the employee restroom. Upon request, the facility failed to provide a policy regarding a sanitary kitchen environment. The facility failed to store, prepare, and serve food under sanitary conditions in one of one facility kitchen, placing the 34 residents at risk for foodborne illness.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 34 residents. The sample contained 13 residents. Based on observations, interviews, and record reviews the facility failed to ensure the use of standard infection control precautions (infection prevention practices which include but are not limited to hand hygiene and use of gloves) while performing pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) wound care for Resident (R) 6 Findings include: - An observation on 09/02/20 at 02:35 PM revealed Licensed Nurse (LN) H (accompanied by Administrative Nurse (AN) D) placed a plastic container, which contained clean wound care supplies, on R6's recliner. She opened the box and placed the lid upside down on the recliner, with no clean barrier underneath. LN H donned gloves placed a clean dressing and a bottle of [MEDICATION NAME] gauze (medicated gauze strips used to pack a wound) on the bedside table, without a clean barrier underneath. She removed the soiled dressing, which appeared to have a moderate amount of bloody drainage on it, and placed it in the trash can. LN H obtained a cotton swab from the plastic container and cleaned the wound. She packed the wound with the [MEDICATION NAME] gauze and placed a clean dressing on the wound. She obtained a packet of skin prep (a liquid film-forming dressing which forms a protective film to help reduce friction during removal of adhesive dressings) from the plastic container and applied to R6's skin around the wound. She adjusted R6's incontinence brief, pants, and blankets. LN H doffed her gloves, cleaned the scissors with an alcohol pad, placed the top back on the plastic box on, took the trash out of the waste can, tied the trash bag, adjusted R6's Foley catheter (tube inserted into the bladder to drain urine into a collection bag) drainage bag, and placed R6's call light within the resident's reach. LN H did not doff gloves, sanitize hands, and don clean gloves in between touching soiled and clean items. On 09/02/20 at 02:45 LN H stated she had received education on wound care in the past. On 09/03/20 at 12:00 PM AN D stated she had noticed several infection control issues with the wound care and had notified the Quality Assurance Director of the issues. The facility's Skin and Wound Assessment, Prevention, and Treatment dated June 2020 documented hand hygiene was preformed upon entering a resident's room, supplies were arranged on an established clean field of the work surface, hands were washed and gloves donned, soiled dressing was removed and gloves doffed, hands washed and clean gloves donned, wound was cleaned and medications applied, gloves removed and hands washed, new gloves donned, the new dressings were applied, and gloves were removed and hands washed with soap and water. The facility failed to ensure nursing staff used standard infection control precautions while performing pressure ulcer wound care. These deficient practices had the potential for transmission and/or development of infections among the residents and staff.