STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	**10/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHILLIPS COUNTY RETIREMENT CENTER	**EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661**

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 34 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to notify the Ombudsman for one sampled resident discharged to the hospital, Resident (R) (4). Findings included: - R4's Physician order [REDACTED]. of sadness, worthlessness, emptiness and hopelessness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The MDS documented the resident required extensive assistance of one staff with most activities of daily living (ADLs). The Medication Care Plan, dated 07/09/20, directed staff to inform the physician of any problems, and monitor for possible signs and symptoms of adverse drug reactions (falls, weight loss, fatigue, incontinence, and gastric upset). The Nurses Note, dated 07/18/20 at 11:50 PM, documented at 03:00 PM staff called the nurse into the dining room to assess R4's temperature of 101.7 degrees Fahrenheit (F) (normal 97-99 degrees F), oxygen saturation at 86% (normal 97-99%), difficulty breathing and diminished lung sounds. Staff notified the resident's family member of the resident's condition and she requested the resident be evaluated at the emergency room (ER). The note documented the nurse notified the physician, and at 06:30 PM Emergency Medical Services (EMS) arrived and transported the resident to the hospital. The Nurses Note, dated 07/21/20 documented the resident returned to the facility with a [DIAGNOSES REDACTED]. The Nurses Note, dated 07/22/20 at 04:39 AM, documented the resident had temperatures that ranged from 98-99 degrees F, oxygen saturation from 70% to 90%, shallow respirations, pale color, and unable to answer questions or respond verbally. Staff notified the resident's family member of the resident's condition and she requested the resident be evaluated at the ER. The note documented the nurse notified the physician, and at 07:39 PM EMS arrived and transported the resident to the hospital. The Nurses Note, dated 07/22/20 at 10:59 AM, documented the resident returned from the hospital late yesterday, went to the ER this morning, and was readmitted to the hospital for observation. The Nurses Note, dated 07/25/20 at 01:02 PM, documented the nurse notified the physician the resident's oxygen saturation levels dropped while oxygen was increased from 2 to 4 liters and the nurse sent the resident to the ER due to declining health. The note documented at 01:38 PM, EMS arrived at the facility and transported the resident to the hospital. The Nurses Note, dated 08/03/20, at 01:24 PM, transportation provided for the resident as she returned from the hospital. The Nurses Note, dated 08/07/20 at 10:42 PM, documented at 09:00 PM the resident ran a low-grade fever with temperature of 100.4 degrees F. At 09:50 PM the resident had a blood pressure reading 76/48 mg Hg (normal 120/80 mg Hg), pulse 85 beats per minute (bpm-normal resting 60 bpm), respirations 24 breaths per minute (normal 12-16 breaths per minute) and oxygen saturation level of 92%. The note documented the facility transported the resident to the hospital. The Nurses Note, dated 08/08/20, documented the resident returned to the facility with a [DIAGNOSES REDACTED].) R4's Medical Record lacked documentation staff notified the ombudsman of the resident's hospitalization s. On 10/12/20 at 10:30 AM, observation revealed R4 sat in a recliner in common area. Observation revealed the nurse attempted to get the resident to wear a face mask, but was not successful. On 10/14/20 at 12:04 PM, Administrative Nurse D stated she did not send the ombudsman notice for the resident's discharges in July and August 2020, but was aware the facility should send the notices. Upon request, the facility was unable to provide a discharge policy. The facility failed to notify the Ombudsman's office of R4's discharges to the hospital, placing the resident at risk to not have Ombudsman advocate for him.
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 had a census of 34 residents. The sample included 12 residents with one reviewed for urinary catheter. Based on observation, record review, and interview, the facility failed to revise Resident (R) 19's care plan with interventions to include urinary catheter (insertion of a tube into the bladder to drain the urine into a collection bag) care and services. Findings included: - R19's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident required total staff assistance for all activities of daily living (ADLs) except eating. The MDS documented the resident frequently incontinent of urine, no catheter, and received diuretic (medication to promote the formation and excretion of urine) and antibiotic (substance active against bacteria) medication seven days of the look back period. The Urinary Care Area Assessment (CAA), dated 11/20/19, documented the resident dependent on staff for toileting, changing of incontinence products, and providing perineal care. The Urinary Care Plan, dated 09/02/20, directed staff to use disposable incontinence briefs, change with each incontinence episode, and monitor for signs and symptoms of UTIs. The update, dated 09/08/20, directed staff to change the resident's urinary catheter monthly, position catheter bag and tubing below the level of the bladder, and ensure drainage bag covered. The care plan directed staff to monitor and document the resident's urinary output per facility policy, monitor for pain or discomfort due to catheter, and report to the physician signs or symptoms of UTI. The care plan further directed staff to administer antibiotic therapy as prescribed, encourage fluids if not contraindicated, monitor for cognitive changes, laboratory results, and evaluate urine characteristics. The Physician Visit Note, dated 08/19/20, documented the resident had recurrent UTIs and [MEDICAL CONDITION] activity that went along with the UTIs. The note documented it was difficult to diagnose a UTI until at times [MEDICAL CONDITION] activity occurred, versus fevers and change in vital signs. Once the resident was treated and the infection cleared, [MEDICAL CONDITION] activity ceased. The note documented the resident recently had a suspected UTI, culture was negative, a repeat urinalysis (examination of urine) came back worse, and while awaiting the culture results the resident had [MEDICAL CONDITION] activity and was sent to the emergency room (ER). The Communication to Physician, dated 08/31/20 at 09:40 AM, documented the resident returned from the hospital 08/26/20 with a urinary catheter without orders for catheter care, how often to change catheter, or a [DIAGNOSES REDACTED]. R19's August Treatment Administration Record (TAR) lacked documentation of urinary catheter output, or care provided, 08/26/20 through 08/31/20. The Progress Note, dated 08/31/20 at 03:12 PM, documented the resident pulled out her catheter this morning. The physician's orders [REDACTED]. On 10/14/20 at 11:38 AM, observation revealed Certified Nurse Aide (CNA) N provided catheter cares appropriately and emptied the catheter drainage bag. CNA N cleaned the catheter port with an alcohol wipe before and after emptying the bag. CNA N held the measuring container and drainage bag off the floor the whole time and practiced proper infection control. On 10/12/20 at 02:30 PM, Licensed Nurse (LN) G verified she had not updated R19's care plan to include the urinary catheter when the resident returned from the hospital on [DATE]. On 10/12/20 at 04:05 PM, CMA R stated staff checked care plans for

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

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F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) information about the resident's care. On 10/14/20 at 12:07 PM, Administrative Nurse D verified the facility readmitted R19 on 08/26/20 with a urinary catheter and staff did not obtain catheter care orders for five days or document routine catheter care or output during those five days. Upon request, the facility did not provide a care plan revision policy. The facility failed to revise R19's care plan to include interventions for a urinary catheter for five days after R19 returned from the hospital with a new urinary catheter, placing the resident at risk for urinary catheter complications.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 34 residents. The sample included 12 residents with one reviewed for urinary catheter. Based on observation, record review, and interview, the facility failed to provide care and services for Resident (R) 19's urinary catheter. Findings included: - R19's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident required total staff assistance for all activities of daily living (ADLs) except eating. The MDS documented the resident frequently incontinent of urine, no catheter, and received diuretic (medication to promote the formation and excretion of urine) and antibiotic (substance active against bacteria) medication seven days of the look back period. The Urinary Care Area Assessment (CAA), dated 11/20/19, documented the resident dependent on staff for toileting, changing of incontinence products, and providing perineal care. The Urinary Care Plan, dated 09/02/20, directed staff to use disposable incontinence briefs, change with each incontinent episode, and monitor for signs and symptoms of UTIs. The update, dated 09/08/20, directed staff to change urinary catheter monthly, position catheter bag and tubing below the level of the bladder and ensure drainage bag covered. The care plan directed staff to monitor and document the resident's output per facility policy, monitor for pain or discomfort due to catheter, and report to the physician signs or symptoms of UTI. The care plan further directed staff to administer antibiotic therapy as prescribed, encourage fluids, if not contraindicated, and monitor for cognitive changes, laboratory results, and evaluate urine characteristics, The Physician Visit Note, dated 08/19/20, documented the resident had recurrent UTIs and [MEDICAL CONDITION] activity that went along with the UTIs. The note documented it was difficult to diagnose a UTI until at times [MEDICAL CONDITION] activity occurred, versus fevers and change in vital signs. Once the resident was treated and the infection cleared, [MEDICAL CONDITION] activity ceased. The note documented the resident recently had a suspected UTI, culture was negative, a repeat urinalysis (examination of urine) came back worse, and while awaiting the culture results the resident had [MEDICAL CONDITION] activity and was sent to the emergency room (ER). The Communication to Physician, dated 08/31/20 at 09:40 AM, documented the resident returned from the hospital 08/26/20 with a urinary catheter without orders for catheter care, how often to change catheter, or a [DIAGNOSES REDACTED]. R19's August Treatment Administration Record (TAR) lacked documentation of urinary catheter output, or care provided, 08/26/20 through 08/31/20. The Progress Note, dated 08/31/20 at 03:12 PM, documented the resident pulled out her catheter this morning. The physician's orders [REDACTED]. The Progress Note, dated 09/08/20 at 09:57 AM, documented staff inserted a urinary catheter into R19 this morning. On 10/12/20 at 11:20 AM, observation revealed R19 in a recliner in the living room, legs elevated, and eyes closed. Further observation revealed urinary catheter drainage bag in a privacy bag to dependent drainage in the side pocket of the recliner. On 10/14/20 at 11:38 AM, observation revealed Certified Nurse Aide (CNA) N provided catheter cares appropriately and emptied the catheter drainage bag. CNA N cleaned the catheter port with an alcohol wipe before and after emptying the bag. CNA N held the measuring container and drainage bag off the floor the whole time and practiced proper infection control. On 10/14/20 at 12:07 PM, Administrative Nurse D verified the facility readmitted R19 on 08/26/20 with a urinary catheter and staff did not obtain catheter care orders for five days or document routine catheter care or output during those five days. The facility's undated Catheter Care policy lacked direction for staff on how often to provide catheter care and document urinary output. The facility failed to obtain urinary catheter orders for care and services upon R19's return to the facility with a urinary catheter, placing the resident at risk for infection and urinary catheter complications.
F 0804 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** The facility had a census of 34 residents. Based on observation, record review, and interview, the facility failed to provide food prepared by methods that conserve nutritive value, flavor and appearance for six of six pureed meals. Findings included: - On 10/12/20 at 10:50 AM, observation during pureed food preparation revealed Dietary Staff (DS) BB used a pasta spoon and placed six scoops of spaghetti, measured six-4 ounce (oz) scoops of meat sauce, two cups of heated tomato juice from stove top, and three slices of bread into the blender and blended to pudding consistency. DS BB then poured the mixture into the warmer on the steam table. On 10/12/20 10:50 AM, DS BB presented a pureed recipe book containing a recipe for pureed vegetables, pureed meat, and pureed fruit. The notebook did not contain a pureed recipe for spaghetti. DS BB stated she did not have a recipe for pureed spaghetti. On 10/12/20 at 11:10 AM, DS BB placed a 4 oz scoop of the pureed spaghetti on six residents plates. On 10/12/20 at 11:15 AM, DS BB verified she did not have a pureed recipe for spaghetti. The facility's revised Preparation of Altered Consistency Diets policy, dated 03/19/2015, documented pureed recipes are to be consulted and followed. The facility failed to provide pureed foods prepared by methods that conserve nutritive value, flavor and appearance for six of six residents on pureed consistency diets, placing the residents at risk for impaired nutrition.
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 had a census of 34 residents. Based on observation, record review, and interview, the facility failed to prepare food in accordance with professional standards for food service safety in the facility kitchen. Findings included: - On 10/12/20 at 11:35 AM, observation during noon meal preparation revealed Dietary Staff (DS) BB performed hand hygiene at a sink in the kitchen, applied gloves, and began placing food on residents' plates. DS BB obtained food portions to place on resident plates, touched the measured utensils, then used the same gloved hand to obtain bread and placed the bread on the resident's plate. On 10/12/20 at 01:50 PM, DS CC produced the Dishwasher PPM test strips (accurately measures the concentration of the sanitizing solution in dishwasher) and noted an expiration date of March 2020 on the test strips. On 10/12/20 at 11:35 AM, DS BB stated she was not aware that using the same gloves to obtain the bread would contaminate the bread and obtained tongs to place the bread on the resident's plates. On 10/12/20 at 01:50 PM, DS CC stated the Dishwasher PPM test strips that were attached to the outside of the dishwasher had an expiration date of March 2020 and were the ones staff used to test the dishwasher sanitizing solution. The facility's Food Safety-Food Service Manager's Responsibility policy, dated 2013 documented the food service manager assures good sanitary food handling practices and sanitary conditions are maintained in the storage, preparation and serving areas. The facility failed to prepare food in accordance with professional standards for food service safety, placing the 34 residents who received food from the facility kitchen at risk for food borne illness.