STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175202	A. BUILDING _____ B. WING _____	**10/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COLBY OPERATOR, LLC	**105 EAST COLLEGE DRIVE COLBY, KS 67701**

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 29 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to notify the ombudsman for two sampled residents' discharge to the hospital, Resident (R) 15, R23. Findings included: - R15's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. The MDS documented the resident required extensive assistance of two staff with most activities of daily living (ADLs) and received Physical Therapy (PT) services. The Fall Care Plan, dated 07/17/20, directed staff to ensure the resident wore appropriate footwear when ambulating, PT to evaluate and treat as ordered or as needed (PRN), re-educate the resident to notify staff if he dropped/spilled anything instead of trying to get something off the floor himself, and do not leave the resident unattended while in his room and in his wheelchair. The Fall Note, dated 05/22/20 at 03:57 PM, documented at 02:40 PM therapy staff informed the nurse the resident had fallen. The resident reported pain in his right hip, and the nurse called the physician who ordered to send the resident to the hospital. The note documented the nurse notified the resident's guardian, gave a report to emergency room (ER) staff, and at 03:30 PM Emergency Medical Services (EMS) arrived and transported the resident to the hospital . The Discharge MDS, dated [DATE], documented the resident discharged to acute care. The Entry MDS, dated [DATE], documented the resident re-entered the facility from acute care. R15's Medical Record lacked documentation staff notified the ombudsman of the resident's hospitalization . On 09/30/20 at 04:45 PM, Certified Nurse Aide (CNA) M answered the resident's call light and found the resident with his feet hanging off the bed. Licensed Nurse (LN) G and CNA M used a gait belt and walker, and assisted the confused resident to the toilet. On 10/05/20 at 02:10 PM, Social Services Staff (SS) X stated he did not send the ombudsman notices for discharged residents, the business office sent those. On 10/05/20 at 02:13 PM, Business Office Staff HH stated she did not send the ombudsman notices for discharges, thought the social services department was responsible for that, but was aware the facility should send the notices. The facility's Transfer or Discharge policy, dated January 2020, documented the facility would send a copy of the reason for discharge to the State Long Term Care Ombudsman and note that in the record. The facility failed to notify the Ombudsman's office of R15's discharge to the hospital, placing the resident at risk for not having the Ombudsman advocate for him. - R23's POS, dated 08/13/20, documented a [DIAGNOSES REDACTED]. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of five, indicating severe cognitive impairment. The MDS documented the resident had hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), and verbal and wandering behaviors. The Discharge MDS, dated [DATE], documented the resident's return was anticipated. The Cognitive Care Plan, dated 08/17/20, directed staff to allow the resident to make decisions about treatment regime, to provide sense of control. If the resident resisted, reassure resident, leave and return 5-10 minutes later or distract the resident from wandering by offering pleasant diversions, such as structured activities, food, conversation, television, or a book. The care plan documented the resident had potential to demonstrate verbally abusive behaviors due to dementia, impaired cognition, and impulse control. The Progress Note, dated 09/25/20 at 11:54 AM, documented staff placed R23 on one to one observation following an incident with another resident. The Progress Note, dated 09/28/20 at 01:22 PM, documented resident discharged from the facility on 09/25/20. On 10/05/20 at 02:10 PM, SS X stated he did not send the ombudsman notices for discharged residents, the business office sent those. On 10/05/20 at 02:13 PM, Business Office Staff HH stated she did not send the ombudsman notices for discharges, thought the social services department was responsible for that, but was aware the facility should send the notices. The facility's Transfer or Discharge policy, dated January 2020, documented the facility would send a copy of the reason for discharge to the State Long Term Care Ombudsman and note that in the record. The facility failed to notify the Ombudsman's office of R23's discharge to the hospital, placing the resident at risk for not having the Ombudsman advocate for him.
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 had a census of 29 residents. The sample included 12 residents. Based on record review and interview, the facility failed to document a discharge summary for one of three sampled residents, Resident (R) 32. Findings included: - R32's Physician order [REDACTED]. The Activities of Daily Living (ADL) Care Plan, dated 06/17/20, directed staff to provide the resident heat/cold applications as ordered and as tolerated, monitor braces and visible skin around the braces for signs and symptoms of skin breakdown, and monitor for compromised circulation to fingers. The care plan further directed staff to provide the resident one staff assistance with bathing, cover casts in plastic to prevent moisture during bathing, and assist the resident with brushing his teeth and personal hygiene activities including brushing hair, shaving, applying deodorant, and washing face and hands. The Progress Note, dated 06/28/20 at 12:09 PM, documented the resident continued doing cares independently, no longer needed bathroom assistance or tray setup, and continued to work with therapies. The note documented the resident complained of dull pain in the right hand but did not request medication for it, and commented that it hurt a lot less than previously. The Progress Note, dated 07/02/20 at 03:50 PM, documented the resident had a follow up appointment with an orthopedic (doctors who specialize in the musculoskeletal system) physician who stated they were comfortable with the resident being dismissed, continuing outpatient therapy with braces as recommended by Physical Therapy (PT), and follow up again in six weeks. The Progress Note, dated 07/06/20 at 11:15 AM, documented the resident continued to be independent with cares and was scheduled to discharge home today. Review of R32's Medical Record revealed no further information regarding the resident's stay at the facility or discharge instructions. On 10/05/20 at 01:50 PM, Administrative Nurse D verified the lack of discharge summary for this resident. The facility's Documentation of Transfers and Discharges policy, dated January 2020, documented the care planning team would record the date and time of the discharge, that the resident or representative participated in a pre-discharge orientation program, the reason for the discharge, the mode of transportation, a summary of the resident's overall medical, physical and mental condition, disposition of drugs and personal effects. The facility failed to document a discharge summary for R32, placing the resident at risk for difficulty in transitioning to the community.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) The facility had a census of 29 residents. The sample included 12 residents with two reviewed for pressure ulcers. Based on observation, interview, and record review, the facility failed to weekly assess one of two sampled residents unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (dead skin) pressure ulcer as care planned, Resident (R) 30. Findings included: - R30's Physician order [REDACTED]. (MRSA-bacteria resistant to some commonly used antibiotics) infection, unstageable pressure ulcer of coccyx (small triangular bone at the base of the spine), severe protein-calorie malnutrition, and osteo[DIAGNOSES REDACTED] (infection in a bone). The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview of Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented the resident required supervision for eating, extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and hygiene. The MDS documented the resident at risk for pressure ulcers (PU), one unstageable PU upon admission, a foot infection, and received PU care of non-surgical dressing and ointments other than to feet. The Quarterly MDS, dated [DATE], documented the same as the 06/22/20 MDS except, the resident had a BIMS score of 11, indicating moderate cognitive impairment, and a condition or disease that may result in a life expectancy of less than six months. The MDS documented the resident had one unstageable PU, a [MEDICAL CONDITION], dressing to feet, and antibiotic medication. The Pressure Ulcer Care Area Assessment (CAA), dated 06/22/20, documented the resident arrived in the facility with an unstageable PU to coccyx with 100% slough (dead tissue). R30 had a history of [REDACTED]. The Pressure Ulcer Care Plan, dated 06/25/20, directed staff to administer the resident medications and wound treatments as ordered, assess and record wound healing every shift, and measure width and length of wound weekly and as needed (PRN). The care plan further directed staff to assess (appearance, size, drainage, pain, odor) and document status of wound perimeter, wound bed, and healing progress weekly and PRN, report declines and delayed healing to the health care provider (HCP), and inform resident and his representative of any new area of skin breakdown. The care plan further directed staff to monitor/document and report to HCP changes in the resident's skin status, obtain and monitor labwork as ordered, report results to HCP, and follow up as indicated. The care plan further directed staff to ensure R30 changed position at least every two hours, assist him when he had not changed position in at least two hours, and wound nurse or designee to monitor wound healing weekly until resolved. The 07/29/20 update documented pressure injuries were not expected to resolve related to the resident's terminal prognosis. The PT Wound Documentation, dated 06/17/20, documented Stage 2 coccyx pressure wound, measured 3.4 centimeters (cm) x 2.1 cm x 0.1 cm, no odor, moderate drainage, and white/gray dead tissue. The wound had no granulation (new connective tissue) tissue and surrounding skin bright red. The Physician Order, dated 06/24/20, directed PT to treat the coccyx wound, debridement and dressing change three times per week, and nursing staff to reapply dressing if soiled or dislodged. The Physical Therapy Wound Form, dated 06/24/20, documented coccyx wound measured 3.4 cm x 2.1 cm x 0.1 cm, Stage 2 with 100% gray/white slough without odor, and skin surrounding wound red and dry. The Physical Therapy Wound Form, dated 07/01/20, documented coccyx wound measured 3.1 cm x 2.1 cm x 0.1 cm with 60% slough, 40% granulation tissue, moderate serosanguinous (both blood and the liquid part of blood) drainage, and no odor. The Physical Therapy Wound Form, dated 07/08/20, documented coccyx wound measured 2.4 cm x 1.7 cm x 0.2 cm with 60% slough, 40% granulation, minimal drainage, and no odor. Review of R30's Medical Record lacked a Physical Therapy Wound Form for 07/15/20. The Physical Therapy Wound Form, dated 07/22/20, documented coccyx wound measured 0.5 cm x 0.5 cm x 0.1 cm, 10% slough and 90% granulation. The Physical Therapy Wound Forms, dated 07/29/20, 08/05/20, 08/19/20, 09/09/20, 09/16/20, lacked a coccyx wound assessment. The Physical Therapy Evaluation and Plan of Care, dated 09/28/20, documented coccyx wound not measured because wound being cared for by nursing staff. The plan of care documented coccyx wound with white/gray dead tissue in less than 25% of wound bed, distinct edges, and 75-100% granulation. The physician's orders [REDACTED]. Review of R30's Medical Record lacked coccyx wound assessments from 07/26/20 to 08/05/20, 08/19/20 to 08/21/20, and 09/02/20 to 09/30/20 with wound appearance, size, drainage, pain, odor. No wound measurements from 08/26/20 to 09/30/20. The Progress Note, dated 10/04/20 at 03:36 AM, documented coccyx wound dressing dislodged during peri care. The wound measured approximately 1 cm x 1 cm x 0.2 cm, no drainage, and surrounding skin with pinpoint open areas noted amongst pale peeling skin. On 09/30/20 at 01:00 PM, observation revealed Licensed Nurse (LN) G checked and changed coccyx wound dressing revealing scant amount of pink drainage, reddened skin around wound extending out approximately two inches, a smaller one cm round wound on the left buttock with granulated tissue, and a 3 cm irregular shaped coccyx wound with some slough. Observation revealed an air mattress on the resident's bed and the resident lying on his back per his choice. On 09/30/20 at 04:28 PM, Administrative Nurse D stated she was unaware of the change in wound care orders, verified Physical Therapy staff did not enter the discharge order correctly, and did not fill out the form to ensure nursing was aware of the wound care change. On 10/05/20 at 01:46 PM, Administrative Nurse D verified therapy or nursing were to perform weekly wound assessments and document. Administrative Nurse D verified the lack of weekly assessments for the resident's coccyx pressure ulcer. The facility's Pressure Injury Treatment Guidelines, dated November 2017, lacked direction regarding the routine assessment and documentation of pressure ulcers. The facility failed to assess R30's coccyx pressure ulcer weekly as care planned, placing the resident at risk for infection and delayed wound healing.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to document the removal and destruction with two licensed staff signatures of Resident (R) 26's [MEDICATION NAME] (narcotic pain patch). Findings included: - R26's Pharmacist Consult Admission Review, dated 08/25/20, documented R26 used [MEDICATION NAME], but it was not apparent that patch placement/removal was being documented. Recommendation: Please document [MEDICATION NAME] placement every shift, and document removal and destruction with two licensed staff signatures or as outlined by policy or regulation. On 10/01/20 at 02:57 PM, review of R26's Narcotic Flow Record lacked documentation of removal and destruction of R26's [MEDICATION NAME]es. On 10/01/20 at 10:00 AM, observation revealed resident waited for staff to take her outside for a cigarette break, hair nicely groomed and styled. On 10/01/20 at 01:03 PM, Certified Medication Aide (CMA) R stated she had a person watch her remove the [MEDICATION NAME], they were supposed to have someone watch them destroy the patch, but the nurse does not sign behind her signature. Also, the person who watched CMA R remove the patch did not sign anywhere. On 10/01/20 at 02:57 PM, Licensed Nurse (LN) H stated she had another nurse with her when they removed the [MEDICATION NAME] and after removal it was placed in the Destroyer RX waste jug with disintegrate chemicals. LN H stated the patch's placement was witnessed each shift change and signed for by two people, but verified the facility lacked a place to sign for witnessing the removal and destruction of [MEDICATION NAME]es. On 10/01/20 at 01:25 PM, Administrative Nurse D stated two people watched the placement of [MEDICATION NAME]es but both did not sign that they watched. The facility's Discarding and Destroying Medications policy, dated ?????, documented Schedule II, III, and IV controlled drugs must be destroyed by the Director of Nursing Services and another licensed nurse or per state law. The facility failed to document the removal and destruction with two licensed staff signatures of R26's [MEDICATION NAME], placing the resident at risk for receiving incorrect medication and pain.
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 had a census of 29 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a safe sanitary environment to prevent the transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. Findings included: - On 09/30/20 at 01:10 PM, observation of Resident (R) 30's wound care revealed Physical Therapy Staff (PT) II wore a face mask and gloves, but no isolation gown while he changed the resident's diabetic [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) infected foot ulcer. PT II stated after the physician amputated the resident's 3rd and 4th toes of his right foot, it became infected, and the ulcers developed. On 10/01/20 at 10:36 AM, observation revealed Housekeeping Staff (HS) U entered room [ROOM NUMBER], contact isolation room, wore an N95 mask, eye protection goggles, and gloves, but no isolation gown. HS U removed the toilet riser and sprayed the outside and inside surfaces of toilet, riser, and sink, with disinfectant spray and left the bathroom. HS U exited the room, removed and discarded gloves at her housekeeping cart, applied alcohol -based hand rub, and donned new gloves. HS U obtained a duster and clean blue dust rags from the housekeeping cart and used the duster to dust higher surfaces of room. HS U removed gloves, applied alcohol- based hand rub, donned new gloves, and obtained red clean rags and a disposable toilet scrubber from housekeeping cart. HS U returned

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) to the bathroom, used the clean red rags and wiped previously spayed toilet surfaces moving from clean to dirty, beginning with the top of toilet tank and handle. HS U applied toilet bowl cleaner to the inside of the toilet bowl and left it to sit. HS U discarded used red rags in housekeeping cart bag, then removed and discarded gloves, applied alcohol-based hand sanitizer and applied new gloves. HS U obtained clean blue dust rags, dusted television and area surrounding television, returned to cart and removed and discarded gloves. Observation revealed HS U applied alcohol-based hand sanitizer, donned new gloves and returned to the bathroom. HS U scrubbed the inside of toilet with disposable toilet scrubber and placed scrubber into holder and took out of room. HS U cleaned the outside of toilet bowl and toilet riser with red rags, placed toilet riser on toilet, discarded used red rags in used bag on housekeeping cart, and removed and discarded her gloves. On 09/30/20 at 01:10 PM, PT II stated he should have put on an isolation gown during the dressing change as the foot [MEDICAL CONDITION] infection in the wound. On 09/30/20 at 01:15 PM, Administrative Nurse E verified PT II should have worn an isolation gown while he provided wound care for this resident. On 10/05/20 at 04:43 PM, Administrative Nurse D verified she expected housekeeping staff to wear an N95 mask, gloves, eye protection, and gown when cleaning isolation rooms. The facility's revised Isolation-Categories of Transmission-Based Precautions policy, dated July 2020, documented in addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, nonsterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. The facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections, placing the residents at risk for infection.
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** The facility had a census of 29 residents. The sample included 12 residents with five reviewed for immunizations. Based on record review and interview, the facility failed to provide two of five sampled residents or their representative current influenza vaccination information, Resident (R) 18, R20. Findings included: - Review of R18's immunization records documented an Influenza Vaccine Consent Form, dated 08/07/15, signed via phone consent 10/09/19 by R18's representative. The medical record lacked the current Vaccine Information, dated 08/15/19. Review of R20's immunization records documented an Influenza Vaccine Consent Form, dated 08/07/15, signed via phone consent 10/09/19 by R20's representative. The medical record lacked the current Vaccine Information, dated 08/15/19. On 10/01/20 at 11:31 AM, Administrative Nurse D stated the facility used the Centers for Disease Control and Prevention (CDC) Informed Consent for Influenza Vaccine form, dated 08/07/2015. The facility's Vaccination of Residents policy, dated January 2020, documented prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations. (See current vaccine information statements at www.cdc.gov/vaccines/pubs/vis/default.htm for educational materials.) The facility failed to provide R18 and R20 or their representatives current influenza vaccination information and education, placing the residents at risk for making an uninformed decision.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** The facility had a census of 29 residents. Based on observation, record review, and interview, the facility failed to provide a sanitary and comfortable environment for the residents who resided in the facility. Findings included: - On 10/01/20 at 10:30 AM, observation revealed the following: One of two ceiling fans in the dining room with gray, fuzzy lint on the blades, that hung down approximately inch (in) and was located over the dining room tables. One of three air ventilation systems in the dining room with black, powdery substance on the output louvers. Two of six air ventilation systems in three of three facility halls lacked a filter. On 10/01/20 at 10:35 AM, during environmental tour, Maintenance Staff (MS) V verified the above findings, and stated he was in the process of changing the louvers on the air ventilators. On 10/01/20 at 10:40 AM, Administrative Staff A verified housekeeping/maintenance staff were responsible for the upkeep of the facility. On 10/02/20 at 03:52 PM, Administrative Staff A stated staff were to inspect and/or change the air filters every three months. Administrative Staff A stated documentation regarding changing air filters was not on the facility policy, but MS V reported to him the filters were to be changed every three months. The facility's undated Air Handlers policy directed staff to inspect air filters, check if installed properly, and replace the filter if needed. The facility failed to provide a sanitary and comfortable environment for the residents that resided in the facility, placing the residents at risk for respiratory issues.