| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175437 | A. BUILDING _____ B. WING _____ | 07/23/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| MCPHERSON OPERATOR, LLC | 1601 N MAIN STREET MCPHERSON, KS 67460 |

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 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility had a census of 42 residents. Based on observation, record review, and interview, the facility failed to provide a safe, clean, comfortable and homelike environment for three resident rooms with environmental damages. Findings included: - On 07/20/20 at 10:44 AM, observation during initial tour revealed the following: room [ROOM NUMBER]'s floor lamp had two light bulbs burnt out and one light fixture with broken piece of plastic. room [ROOM NUMBER]'s wall by the bed with scraped paint approximately 3 feet (ft) by 2 ft wide. A loose tile underneath the right foot of the bed approximately 8 Inches (in) x 8 in coming up from the floor. room [ROOM NUMBER]'s closet door with approximately 4 ft by 4 ft area of scraped paint all along the bottom of the door. On 07/22/20 at 10:51 AM, during environmental tour, Maintenance Staff (MS) V verified the above findings, stated he fixed the light bulbs yesterday, and was unaware of the other findings. MS V stated staff were to document environmental issues in the facility's computer system or tell him personally. The facility's Work Orders, Maintenance policy, dated January 2020, documented in order to establish a priority of maintenance service, work orders must be filled out and forwarded to the maintenance director. Work order requests should be placed in the appropriate file basket at the nurse's station. Worked orders are picked up daily or noted daily in facility computer system. The facility failed to provide maintenance services necessary to maintain a comfortable interior for three resident rooms, placing the residents at risk for an unsafe and uncomfortable environment. |
| F 0685<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Assist a resident in gaining access to vision and hearing services.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility had a census of 42 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 16 received a requested assistive device to maintain his hearing abilities. Findings included: - R16's Admission Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented the resident had highly impaired hearing and no hearing aids or hearing devices. The 05/21/20 Activities of Daily Living (ADLs) Care Plan instructed staff to anticipate and meet R16's hearing needs, discuss with resident/family concerns or feelings regarding communication difficulty, and validate the resident's message by repeating aloud. Review of the Social Service Notes from 03/11/20 through 07/22/20 lacked documentation of the resident's requests for a hearing device. On 07/22/20 at 09:14 AM, observation revealed the resident sat in a wheelchair with his right ear next to the television screen, with the volume loud. On 07/23/20 at 09:12 AM, Licensed Nurse (LN) G stated when she wanted to communicate something to the resident she would get close to his ear and cover her mouth with her hand over his ear, so the resident could hear what she said. LN G stated staff attempted to get the resident a hearing aid, but the hearing doctor was currently not open. On 07/22/20 at 08:42 AM, Social Service Director (SSD) X stated she talked to the resident on 03/11/20 about getting a hearing amplifier but did not document their conversation. SSD X stated she was not sure if she could send the resident out of facility at this time, so she had not followed up on the resident's request for a hearing device. On 07/23/20 at 10:45 AM, Administrative Nurse D stated she expected staff to follow up within a week on the resident's request for a hearing device. The facility's Social Service policy, dated January 2020, documented social services would work with individuals and groups in developing supportive services for residents according to their individual needs and interests. The facility failed to follow up on R16's request for a hearing device, placing the resident at risk for social isolation and lack of communication. |
| F 0756<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility had a census of 42 residents. The sample included 13 residents with six reviewed for unnecessary medications. Based on observations, record review, and interview, the facility's Consultant Pharmacist failed to follow up with the physician and Director on Nursing on recommendations to establish individualized physician ordered blood sugar parameters for one of six sampled residents, Resident (R) 4. Findings included: - R4's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and no behaviors. The MDS recorded R4 required limited staff assistance with Activities of Daily Living (ADL's), diabetes mellitus (when the body cannot use glucose, not enough insulin produced, or the body cannot respond to insulin), and received insulin (hormone that regulates blood sugar levels) injections seven days a week. The Diabetes Care Plan, dated 06/02/20, directed staff to monitor R4's blood sugar and administer insulin as physician ordered. The care plan did not include individualized blood sugar parameters to identify abnormal blood sugars, and direct staff when to notify the physician. The Consultant Pharmacist's Monthly Medication Review, dated 02/05/20, recommended staff implement individualized physician ordered blood sugar parameters for R4. The facility's Physician's Standing Order, dated 04/01/19, directed staff to provide a comprehensive assessment and notify the physician if blood sugar less than 70 milligrams/deciliter (mg/dl) or greater than 400 mg/dl. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The Consultant Pharmacist's Monthly Medication Review, dated 07/17/20, recorded staff had not acted on the 02/05/20 recommendation to implement physician ordered blood sugar parameters for R4. R4's February 5-29, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 02/21/20 at 09:47 AM - 63 mg/dl R4's March 1-31, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 03/10/20 at 06:13 AM - 61 mg/dl 03/25/20 at 12:50 PM - 402 mg/dl R4's May 1-31, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 05/24/20 at 12:14 PM - 68 mg/dl 05/27/20 at 08:25 PM - 409 mg/dl R4's June 1-30, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 06/09/20 at 05:00 AM - 58 mg/dl 06/09/20 at 06:19 AM - 68 mg/dl 06/17/20 at 05:00 PM - 56 mg/dl R4's July 1-31, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 07/07/20 at 06:06 AM - 65 mg/dl 07/08/20 at 10:58 AM - 57 mg/dl 07/10/20 at 09:19 AM - 62 mg/dl 07/11/20 at 06:00 AM - 61 mg/dl 07/16/20 at 05:56 AM - 54 mg/dl 07/19/20 at 06:41 AM - 63 mg/dl On 07/23/20 at 03:02 PM, observation revealed R4 sat in a recliner in her room with a jar of peanut butter and assorted snacks within reach on a bedside table. On 07/23/20 at 09:39, Licensed Nurse (LN) G stated staff checked R4's blood sugar five times a day and administered insulin as physician ordered. LN G stated R4 did |

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 0756<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>not have individualized blood sugar parameters and staff should notify the physician as directed by the facility's standing order blood sugar parameters. LN G stated staff should assess R4 after an abnormal blood sugar, provide appropriate treatment, and recheck the blood sugar. On 07/23/20 at 09:10 AM, Administrative Nurse D stated staff should establish individualized physician ordered blood sugar parameters for R4 as recommended by the facility's Consultant Pharmacist The facility's Medication Review policy, dated November 2016, directed the facility's Consultant Pharmacist to report medication irregularities to the Director of Nursing, and staff act upon the recommendations in a timely manner to address inadequate monitoring, and prevent adverse consequences. The facility's Consultant Pharmacist failed to follow up with the physician and Director on Nursing on recommendations to establish individualized physician ordered blood sugar parameters for R4, placing the resident at risk for continued abnormal blood sugars and adverse side effects. |
| F 0757<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility had a census of 42 residents. The sample included 13 residents with six reviewed for unnecessary medications. Based on observations, record review, and interview, the facility failed to establish an individualized physician ordered blood sugar parameter, adequately monitor, appropriately assess, recheck blood sugars out of the physician ordered parameters, and notify the physician for one of six sampled residents, Resident (R) 4. Findings included: - R4's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact) and no behaviors. The MDS recorded R4 required limited staff assistance with Activities of Daily Living (ADLs), diabetes mellitus (when the body cannot use glucose, not enough insulin produced, or the body cannot respond to insulin), and received insulin (hormone that regulates blood sugar levels) injections seven days a week. The Diabetes Care Plan, dated 06/02/20, directed staff to monitor R4's blood sugar and administer insulin as physician ordered. The care plan did not include individualized blood sugar parameter to notify the physician or interventions to direct appropriate care and treatment for [REDACTED]. The facility's Physician's Standing Order, dated 04/01/19, directed staff to provide a comprehensive assessment and notify the physician if blood sugar less than 70 milligrams/deciliter (mg/dl) or greater than 400 mg/dl. The physician's orders [REDACTED]. The orders did not include individualized blood sugar parameters. The Consultant Pharmacist's Monthly Medication Review, dated 07/17/20, recorded staff had not acted on the 02/05/20 recommendation to implement an individualized physician ordered blood sugar parameter for R4. R4's February 5-29, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 02/21/20 at 09:47 AM - 63 mg/dl R4's March 1-31, 2020 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 03/10/2020 at 06:13 AM - 61 mg/dl 03/25/2020 at 12:50 PM - 402 mg/dl R4's May 1-31, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 05/24/20 at 12:14 PM - 68 mg/dl 05/27/20 at 08:25 PM - 409 mg/dl R4's June 1-30, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 06/09/20 at 05:00 AM - 58 mg/dl 06/09/20 at 06:19 AM - 68 mg/dl 06/17/20 at 05:00 PM - 56 mg/dl R4's July 1-31, 20 Blood Sugar Report recorded the following blood sugars out of physician ordered parameters without a comprehensive nurse assessment or physician notification: 07/07/20 at 06:06 AM - 65 mg/dl 07/08/20 at 10:58 AM - 57 mg/dl 07/10/20 at 09:19 AM - 62 mg/dl 07/11/20 at 06:00 AM - 61 mg/dl 07/16/20 at 05:56 AM - 54 mg/dl 07/19/20 at 06:41 AM - 63 mg/dl On 07/23/20 at 03:02 PM, observation revealed R4 sat in a recliner in her room with a jar of peanut butter and assorted snacks within reach on a bedside table. On 07/23/20 at 09:39 AM, Licensed Nurse (LN) G stated staff checked R4's blood sugar five times a day and administered insulin as ordered by the physician. LN G stated R4 did not have individualized blood sugar parameters, and staff should notify the physician as directed by the facility's standing order blood sugar parameter. LN G also stated staff should assess R4 after an abnormal blood sugar, provide appropriate treatment, and recheck the blood sugar. On 07/23/20 at 09:10 AM, Administrative Nurse D stated R4 should have individualized blood sugar parameters as recommended by the facility's Pharmacist Consultant. Administrative Nurse D stated staff should assess R4 when blood sugars were out of the blood sugar parameter, recheck the blood sugar, notify the physician, and document the event in the resident's progress notes. The facility's Nursing Care for a Resident with Diabetes policy, dated October 2010, directed staff to check blood sugars and administer insulin as ordered by the physician, assess residents with abnormal blood sugars, provide appropriate interventions, and notify the physician as needed. The facility failed to establish individualized physician ordered blood sugar parameters for R4. The facility failed to adequately monitor, appropriately assess, notify the physician, and recheck blood sugars out of the physician ordered parameters, placing the resident at risk for continued abnormal blood sugars and adverse side effects. |
| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility had a census of 42 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to appropriately label five insulin (hormone that is produced in the body which works by lowering levels of glucose (sugar) in the blood) pens and one insulin vial with the date opened for three sampled residents and two unsampled residents, Resident (R) 2, R6, R17, R29, R40. Findings included: - On 07/20/20 at 09:09 AM, observation of the medication cart for Antique Street and Presidential Avenue revealed: R2's [MEDICATION NAME] (long acting man-made form of insulin) pen, opened and undated. R6's [MEDICATION NAME] 70/30 (intermediate acting insulin) pen, opened and undated. R17's [MEDICATION NAME] (short acting insulin) and [MEDICATION NAME] (long acting insulin) pens, opened and undated. R29's Toujeo (long acting man-made insulin) vial, opened and undated. R40's [MEDICATION NAME]pen, opened and undated. On 07/20/20 at 09:09 AM, Licensed Nurse (LN) H verified the insulin pens and vial should have been dated when opened. LN H stated the medication cart was checked for outdated medications by staff and the pharmacist periodically. On 07/23/20 at 10:45 AM, Administrative Nurse D verified staff were to date insulin pens/vials when opened. The facility's undated General Dose Preparation and Medication Administration policy directed staff to enter the date opened on the label of medications with shortened expiration dates, such as insulins. The facility failed to appropriately label five insulin pens and one insulin vial with the date opened for five residents in the facility, placing the five residents at risk to receive ineffective insulin. |
| F 0801<br><br>**Level of harm** - Potential for minimal harm<br><br>**Residents Affected** - Many | **Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.**<br><br>The facility had a census of 42 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to employ a certified dietary manager to carry out the functions of food and nutrition services to meet the needs of the 42 residents in the facility who received meals from one of one kitchen. Findings included: - On 07/20/20 at 08:34 AM, observation revealed all dietary staff with face masks and hairnets, including Dietary Staff (DS) BB, preparing food in the facility kitchen. On 07/22/20 at 11:50 AM, DS BB stated she completed culinary school but lacked certification for Dietary Manager. DS BB stated the Professional Development Services Association of Nutrition and Food Service Professionals required her to work in food service for two years before applying for the Dietary Manager exam. DS BB stated she had worked as the Dietary Manager of the facility for one and a half years. On 07/23/20 at 08:13 AM, Administrative Staff A verified DS BB was not certified. Upon request, the facility failed to provide a Certified Dietary Manager policy. The facility failed to employ a certified dietary manager to carry out the functions of food and nutrition services to meet the needs of the 42 residents who received meals from the facility kitchen, placing the residents at risk for inadequate nutrition. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Provide and implement an infection prevention and control program.**<br><br>The facility had a census of 42 residents. The sample included 13 residents. Based on observation, record review, and |

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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 2)<br>interview the facility failed to provide a sanitary environment to help prevent the development and transmission of communicable diseases and infections, when staff entered Resident (R) 33's isolation room without applying Personal Protective Equipment (PPE), placed R33's soiled clothing in a clear unlabeled trash bag with other residents laundry, and provided incontinent cares without changing gloves after providing peri care. Findings included: - On 07/21/20 at 02:15 PM, observation revealed CNA M and CNA N applied PPE (consisting of a mask, gown, and gloves) and entered R33's room. Observation revealed CNA M and CNA N used a full lift (mechanical device used to transfer people usually from a bed to chair or visa versa) and transferred the resident from a recliner to his bed. Further observation revealed CNA N removed the residents wet shorts, placed them in a clear plastic trash bag from the trash can, and placed the trash bag on the floor. Continued observation revealed CNA N, wearing the same soiled gloves, returned to the resident's bedside and assisted CNA M in unfastening the resident's soiled with bowel movement incontinent brief. Observation revealed CNA N handed CNA M wet incontinent wipes while CNA M provided peri care to the residents front peri area, CMA M requested CNA N hand her an incontinent wipe and stated she was going to wipe off her gloved hands so she would not have to take them off, then proceeded to do so. Continued observation revealed CNA M assisted CNA N reposition the resident to his left side and touched the resident's clothes and bedding with the same soiled gloves. CNA N provided peri care to the residents buttocks, removed the soiled incontinent brief, placed it in a red bag, and placed a clean incontinent brief underneath the resident wearing the same soiled gloves. Continued observation revealed both CNA's, wearing the same soiled gloves, repositioned the resident from side to side touched the resident's clothing and bedding, then removed and discarded their gloves. Continued observation revealed CNA N took the unlabeled clear trash bag with the resident's wet shorts, went into the hall, opened the closet door, and placed it on top of other resident's dirty laundry. On 07/21/20 at 02:00 PM, observation revealed a plastic isolation cart outside R33's room with a sheet on the wall above the isolation cart documenting to see nurse before entering room. Observation revealed Certified Nurse Aide (CNA) M knocked on the resident's door, entered the room (without applying PPE), and asked the resident how he was doing. On 07/21/20 at 02:00 PM, when asked if she should be wearing PPE equipment prior to entering R33's room, CNA M stated, oh, no the resident was not on isolation precautions. When asked what the cart outside the door meant, CNA M opened the drawers of the isolation cart to reveal no gowns. On top of the cart was a box of gloves, and masks. CNA M stated, maybe he is on isolation precautions, the nurse had not told her the resident was on isolation precautions, she would check and went down the hall. Further observation revealed CNA M came back to the room with gowns, asked the nurse coming down the hall if the resident was on isolation, and the nurse replied yes. On 07/22/20 at 12:01 PM, Licensed Nurse (LN) G stated staff should place an isolation resident's clothing in a clear plastic trash bag and mark the bag isolation with a red marker so laundry would know it came from an isolation room. On 07/22/20 at 04:15 PM. Laundry Staff (LS) U stated staff should bring isolation resident's laundry to the laundry room in red or yellow bags. On 07/23/20 at 10:45 AM, Administrative Nurse D stated staff were notified a resident was in isolation during walking rounds with prior shift staff, it was posted at the nursing desk, and an isolation cart with posting above the cart was placed outside the resident's room. Administrative Nurse D stated staff should change gloves during urinary incontinence cares from dirty to clean and should place an isolation resident's soiled clothing in a regular trash bag, if soiled double bag, and label the bag isolation. The facility's Personal Protective Equipment-Gloves policy, dated January 2020, documented all employees must wear gloves when touching blood, body fluids, secretions, excretions, mucous membranes, and or non-intact skin. The policy documented gloves should be used only once and discarded into the appropriate receptacle located in the room in which the procedure is being performed. The facility's Infection Prevention and Control Program policy, dated March 2020, documented the infection prevention and control program is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to provide a sanitary environment to prevent the development and transmission of communicable diseases when staff walked into an isolation room without PPE, placed an isolation resident's soiled clothing in a clear unlabeled trash bag with other resident's clothing, and failed to appropriately change gloves during incontinent cares. |