| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **175223** | A. BUILDING _____ B. WING _____ | **09/09/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **CHASE COUNTY OPERATOR LLC** | **612 WALNUT, PO BOX 589 COTTONWOOD FALLS, KS 66845** |

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** - Some | **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><br>The facility reported a census of 28 residents. Based on observation and interview the facility failed to maintain safe, clean, comfortable and home like environment on three resident hallways and in the activity room, for the residents of the facility who utilized these resident areas. Findings included: - On 09/08/2020 at 12:00 PM, during environmental tour of the facility, with Administrative Staff A and Housekeeping/Maintenance Staff U, revealed the following areas in need of housekeeping/maintenance: 1. The activity room's entryway threshold had indented area where the tiles chipped out across the entryway. 2. The floor tiles between the fire doors, on hallway 3, contained an indented area of chipped tiles across the hallway. 3. The threshold between the activities room and dining room, contained chipping floor tiles. 4. The activities room floor contained four chipped out floor tiles. 5. The lower wall, beneath the handrail, along hallway 2, contained various scrapping all along the walls. On 09/09/2020 at 01:34 PM, Administrative Staff A and Housekeeping/Maintenance U acknowledged the need for these noted areas to be repaired. The facility's policy Safe, Clean, Comfortable, Homelike Environment, revision date of 11/2017, revealed the facility needed to be maintained in a safe, clean, comfortable and homelike environment. The facility failed to maintain a safe, clean, comfortable and homelike environment on three resident hallways and in the activity room, for the residents of the facility. |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility reported a census of 28 residents with 14 selected for review including two residents reviewed for skin conditions. Based on observation, interview, and record review, the facility failed to complete a thorough skin assessment and monitor the cushion for breakdown for one of the two residents, Resident (R)19. Findings included: - The Order Summary Report, dated 05/13/20, for Resident (R)19, included [DIAGNOSES REDACTED]. The annual Minimum Data Set (MDS), date 06/24/20, assessed R19 as having a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact. R19 was independent with setup assistance for transfers and toileting, was always continent of bowel and bladder, and at risk for developing pressure ulcers. She had no ulcers or other skin conditions present, had a pressure reducing device for her bed and her chair, and received an application of ointments/medications other than to her feet. The quarterly MDS, dated [DATE] assessed R19 as having a BIMS score of 15. She received supervision and one assist for transfers, limited assist of one person for toilet use, and was always continent of bowel and bladder. Furthermore, she was not at risk for developing pressure ulcers, had no ulcers or other skin problems present, and had a pressure reducing device to her bed. The ADL Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 06/29/20, indicated R19 required limited assistance with ambulation and locomotion, used a wheelchair for mobility outside of her room, and required supervision to limited assistance with other areas of activities of daily living (ADL's). The Pressure Ulcer/Injury CAA,, dated 06/29/20, indicated R19 was at risk for pressure injury due to her Braden (a tool used to assess a patient's risk of developing a pressure ulcer) score. She required supervision to limited assistance with transfers and mobility, her skin was clean, dry, and free from pressure related issues. The Care Plan, dated 06/19/20, indicated R19 was at risk for impairment of her skin integrity related to her [DIAGNOSES REDACTED]. Furthermore, she had a history of [REDACTED]. The interventions included on the care plan were to monitor/document the location, size and treatment of [REDACTED]. to the medical doctor. Staff were to identify/document potential causative factors and eliminate/resolve where possible. The care plan included that R19 has an ADL self-care performance deficit related to depression and obesity. She wore a pull-up or pad per her preference for fluctuating periods of incontinence of both bowel and bladder. Her hygiene care items and supplies were to be set-up at the bedside as needed. R19 preferred to use her recliner and could get in and out of it by herself and would ask for assistance sometimes. She would transfer independently or with assistance of one depending on how she was feeling. Furthermore, she required supervision to one staff assistance for toilet use. The Weekly Skin Assessment Evaluation, dated 08/09/20, indicated her skin was intact, dry, a rash was present, and there were no open areas. Furthermore, the assessment revealed there was [MEDICAL CONDITION] (rash of the skin) to her right buttock, and [MEDICATION NAME] (a steroid cream used for inflammation) applied. The Weekly Skin Assessment Evaluation, dated 08/16/20, indicated her skin was intact, dry, a rash was present, and there were no open areas. The assessment lacked description of the skin as to location of the rash. The Weekly Skin Assessment Evaluation, dated 08/23/20 indicated her skin was dry, had redness, and there were no open areas. The assessment lacked description of the skin as to location of the redness. The Weekly Skin Assessment Evaluation, dated 09/06/20, indicated her skin was intact, dry, had redness, and there were no open areas. The assessment lacked description of the skin as to location of the redness. On 09/02/20 at 04:53 PM, R19 reported that she had a place on her bottom from sitting on it all the time and that the staff apply a cream to it two to three times a day. On 09/02/20 at 04:54 PM, R19 had a burgundy colored elevated area on her right lower shin area that contained a small scab within the discolored area. On 09/08/20 at 10:03 AM, R19 reported that she toilets herself, her bottom felt better, and that the staff had been putting medicine on it. They applied some today and would be doing it again this afternoon. Furthermore, she reported that the aides apply the medicine. On 9/08/20 at 12:05 PM, R19's wheelchair contained a seat cushion in place, and she was sitting in her recliner. On 09/08/20 at 12:06 PM, R19 reported that she told the nurse about her bottom, the nurse looked at it, and there was a small sore there. Furthermore, she reported that the nurse was going to get a cushion for her to have in the recliner in her room. On 09/08/20 at 12:09 PM, Certified Nurse Aide (CNA) M revealed he does not put any kind of ointment on R19's buttocks, R19 toilets herself, and he only helps her if she wants her pad changed. CNA M does not see her buttocks at those times. On 09/08/20 at 12:14 PM, Licensed Nurse (LN) G, revealed that barrier cream is applied by the CNA's at least daily to her buttocks. LN G reported that she just looked at R19's buttocks a little bit ago and it looked like there was a scratch, possible shearing present. On 09/08/20 at 02:09 PM, R19 reported that her cushion in her wheelchair was not that comfortable, she had it for a while, and that the facility was going to find a temporary one for the recliner until the one they ordered came in. On 09/08/20 at 02:16 PM, observation of R19's buttocks with LN G present, revealed a V shaped superficial purple area to the right inner buttocks, and a pinpoint open area to her left inner buttocks. Her inner buttocks were pink with red edges and blanchable. On 09/08/20 at 02:18 PM, LN G revealed she was not sure how she would measure the V area, and that the discoloration to her right lower shin was normally like that, as the staff monitor the area but do not measure it. The scab was a pinpoint sized area today. On 09/08/20 at 02:22 PM, LN G wiped the resident's inner buttocks with a premoistened wipe and R19 complained of burning. Next, LN G applied barrier cream to |

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 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>her inner buttocks. Then LN G assisted the resident to change her incontinent product due to moisture being present. LN G confirmed that the cushion in R19's wheelchair was hard and wrinkles were present to it under the cover. Furthermore, LN G was not sure how long she had that cushion and that the facility was getting her a new one. On 09/08/20 at 02:43 PM, Administrative Nurse D confirmed that the nurses should explain on weekly skin assessments any areas of redness or rash on the assessment. The discoloration on her right shin area should be monitored and measured and a note about it weekly when doing the skin assessment. Furthermore, she reported that therapy was responsible for assessing the residents' seat cushions. The progress note, dated 09/09/20 at 10:40 AM, indicated R19 had an area of sheering to her right buttock that measured 0.3 centimeters (cm) by 0.1 cm and scabbed over. The staff cleansed the area and applied barrier cream. The surrounding skin had blanchable redness, and the facility was getting a new pressure cushion. On 09/09/20 at 02:11 PM, LN H reported she was made aware of the area to the resident's buttocks by Administrative Nurse D and so she assessed the area today. Furthermore, she revealed the treatment would continue with barrier cream and that the facility ordered a new cushion. On 09/09/20 at 02:20 PM, Consultant staff GG reported that they assess cushions when the resident is on caseload as needed in case they have a sore, or maybe having pain, to evaluate and find the appropriate cushion for them, then they would make recommendations from there. Furthermore, he was not aware if there was a schedule to routinely check cushions for breakdown, as the therapy manager would be in charge of that. The facility policy, Skin integrity, Pressure Injuries Nursing Protocol, dated 01/2020, instructed to provide appropriate, pressure redistributing report surfaces. The facility policy Pressure Injury/Skin Breakdown-Clinical Guidelines, dated 01/2020, instructed that the nursing staff will complete and evaluation of the skin weekly. The facility failed to complete a thorough skin assessment and monitor the cushion for breakdown for Resident (R)19, with a history of skin issues. |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>The facility reported a census of 28 residents with 14 selected for review, including three residents reviewed for respiratory care. Based on observation, interview, and record review, the facility failed to provide the three sampled residents with appropriate respiratory services to prevent respiratory infections, which included failure to clean, date, and store the nebulizer tubing and kit for Resident (R) 12, failed to date and store the nebulizer tubing for R23, and failed to date the oxygen tubing, date the humidifier bottle, clean the oxygen concentrator filter, place an open date on the distilled water jug used for the humidifier bottle, and store the distilled water jug appropriately for R26. These practices increased the risk for developing respiratory infections. Findings included: - The Order Summary Report, dated 05/14/20, for Resident (R)26, included a [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed R26 with a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitively intact, a [DIAGNOSES REDACTED]. The quarterly MDS, dated [DATE], assessed R26 with a BIMS score of 15 and a [DIAGNOSES REDACTED]. R26 was not assessed as having shortness of breath but did use oxygen while in the facility. The Care Plan, dated 07/09/20, included that R26 was on oxygen therapy related to dyspnea. The Order Summary Report, dated 05/14/20, included an order dated, 03/20/20 to apply oxygen to keep the resident's oxygen saturations above 89%. The Treatment Administration Record, for 09/2020, included R26 with documented oxygen saturation levels between 92-97%. On 09/02/20 at 09:30 AM, observation of R26's oxygen concentrator revealed the filter contained a build-up of dust and lint, the oxygen tubing and humidifier bottle lacked a date, and the distilled water container that was half full, sat directly on the floor and also lacked and open date. On 09/08/20 at 09:50 AM, observation of R26's oxygen concentrator revealed the filter remained dirty with lint, the humidifier bottle was sitting directly on the floor, and the distilled water container was half full and sitting directly on the floor and lacked an open date. On 09/08/20 at 04:00 PM, Administrative Nurse D reported that the maintenance supervisor changed the oxygen concentrator filters and was not aware of how often they were cleaned. On 09/08/20 at 04:04 PM, Administrative Nurse D went to R26's room and confirmed the humidifier bottle should not be setting directly on the floor, staff used the distilled water container for the humidifier bottle and it should have an open date and not be stored on the floor. Furthermore, Administrative Nurse D confirmed that the oxygen concentrator filter needed cleaning. On 09/09/20 at 02:13 PM, Maintenance staff U reported that he cleans the oxygen concentrator filters as needed and checked them every two weeks to see if they need cleaned. Furthermore, he was unable to recall the last time he cleaned the filter for R26's oxygen concentrator and confirmed it needed cleaned when observed. The facility policy, Oxygen Administration, dated 02/2020, lacked instruction for dating the oxygen tubing and the humidifier bottle, lacked instruction for cleaning the oxygen concentrator filters, and lacked instruction for storage of distilled water and placing an open date on the container. The facility failed to clean the resident's oxygen concentrator filter, failed to date the oxygen tubing and humidifier bottle, and failed to add the open date to the distilled water container and store it off of the floor, which could increase the risk of R26 developing a respiratory infection. - The Order Summary Report, dated 06/29/20, for Resident (R)12, included a [DIAGNOSES REDACTED]. The quarterly MDS, dated [DATE], assessed R12 with a BIMS score of 8, indicating moderate cognitive impairment, no shortness of breath, and the resident did not receive any respiratory therapy. The Order Summary Report, dated 06/29/20, included an order dated 05/15/19 for [MEDICATION NAME] (medication used to help treat airway narrowing) solution 0.5-2.5 three milligram (mg) per milliliter (mL), inhale three mL via nebulizer, every four hours as needed for shortness of breath. Review of the current Medication Administration Record [REDACTED]. On 09/02/20 at 09:47 AM, observation revealed R26's nebulizer kit remained connected to the tubing, connected to the nebulizer machine and placed in a basket that had papers and snacks in it. The mask of the kit was visibly dirty with smears present, with the tubing and kit lacking a date. Further observations on 09/03/20 at 12:03 PM, and 09/08/20 at 09:57 AM, revealed no changes to the observation made on 09/02/20 at 09:47 AM. On 09/08/20 at 03:58 PM, Administrative Nurse D stated that she expected the nebulizer tubing to be changed once a week, it should be stored in a bag when not in use and labeled with the date and the resident initials. The kit should be cleaned per policy after use. On 09/09/20 at 08:42 AM, the nebulizer tubing contained a date of 09/08/20 and the kit remained connected and stored in a plastic bag dated 09/08/20 with the resident initials. The nebulizer mask however, still contained the same smears as observed on 09/02/20. On 09/09/20 at 08:53 AM, Licensed Nurse (LN) H confirmed R26's last breathing treatment she received was on 08/14/20. She reported that the kit should be changed weekly on Saturday nights. Furthermore, she reported that after a treatment, the kit was to be cleaned with soap and water, soaked in alcohol for five minutes, rinsed with sterile water, and laid out on a paper towel to dry. Once it was dry, it was to be stored in a plastic bag or sealed container. LN H confirmed that R26's kit should be stored with the pieces separated and that the staff failed to appropriately clean the resident's mask after use. The facility policy, Administering Medications through a Small Volume (Handheld) Nebulizer, dated 01/2020, instructed after the treatment to wash pieces with warm, soapy water, rinse with hot water, place all pieces in a bowl and cover with [MEDICATION NAME] (rubbing) alcohol, and soak for five minutes. Then, rinse all pieces with sterile water (not tap, bottled, or distilled), and allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and date on it and change the equipment and tubing every seven days or according to facility protocol. The facility failed to appropriately clean, date, and store the nebulizer kit according to facility policy to ensure adequate sanitation, to prevent the resident from developing a respiratory infection. - The Order Summary Report, dated 08/24/20, for Resident (R)23, included [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], assessed R23 as having a Brief Interview of Mental Status (BIMS) score of three, indicating severe cognitive impairment, no shortness of breath, no oxygen use, and no respiratory therapy. The quarterly MDS, dated [DATE], assessed R23 as having a BIMS score of 11, indicating moderate cognitive impairment, shortness of breath or difficulty breathing with exertion and lying flat, no oxygen use, and no respiratory therapy. The Order Summary Report dated 08/24/20, included an order dated 02/16/20 for [MEDICATION NAME] (medication used to help treat airway narrowing) nebulization solution 2.5 milligrams (mg)/ three milliliters (mL) 0.083%. Give three mL to inhale orally via nebulizer every six hours as needed for shortness of breath related to [MEDICAL CONDITION]. On 09/02/20 at 10:09 AM, it was observed that R23's nebulizer kit remained connected and laying in a drawer on top of a plastic spoon. The kit and tubing lacked a date. On 09/08/20 at 03:58 PM, Administrative Nurse D stated that she expected the nebulizer tubing to be changed once a week, should be stored in a bag when not in use, and labeled with the date and the resident initials. The kit should be cleaned per policy after use. The facility policy, Administering Medications through a Small Volume (Handheld) Nebulizer, dated 01/2020, instructed after the treatment to wash pieces with warm, soapy water, rinse with hot water, place all pieces in a bowl and cover with [MEDICATION NAME] (rubbing) alcohol, and soak for five minutes. Then, rinse all pieces with sterile water (not tap, bottled, or distilled), and allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and date on it and change the equipment and tubing every seven days or according to facility protocol. The facility failed to ensure adequate sanitation for the resident's nebulizer kit |

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| F 0695<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>according to facility policy which increased the risk of R23 developing a respiratory infection. |
| F 0921<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.**<br><br>The facility reported a census of 28 residents. Based on observation and interview the facility failed to maintain a safe, clean, and sanitary environment in the kitchen for the residents in the facility. Findings included: -On 09/08/2020 at 11 AM, during a tour of the kitchen areas, revealed the following areas of concern in need of cleaning and/or repair: 1. The floor by the exit door, by the True Freezer, contained an excessive grease and grime build-up on the floor. 2. The lower area next to the exit door next, by the True Freezer lacked the baseboard. 3. The attic fan, over the dishwasher machine contained excessive dust build-up on each of the blades. 4. The ceiling, next to the attic fan, contained an excessive dust build-up around and near the fan. 5. The three open cabinets contained aged shelf paper detaching from the cabinets in several various areas. 6. The ceiling supporting the open cabinets contained a crack, approximately eighteen inches long. 7. The ceiling over the dishwasher contained four ceiling tiles that hung downward away from the ceiling. 8. The food preparation area, contained a red four plug outlet on the east wall which contained a crack through it. On 09/09/2020 at 01:16, PM Administrative Staff A and Housekeeping/Maintenance U both stated they were unaware of these environmental concerns in the kitchen. The facility failed to provide a policy for Safe, Clean, and Sanitary Environment in the facility's kitchen. The facility failed to maintain a Safe, Clean, and Sanitary Environment in the kitchen for the residents in the facility. |