STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175200	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENWOOD VIEW HEALTH AND REHABILITATION CENTER	900 ELMHURST BLVD SALINA, KS 67401

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F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. The sample included 16 residents. Based on observation, record review and interview, the facility failed to provide a private telephone for resident use, for one of 16 sampled residents, Resident (R) 12. Findings included: - R12's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment and required staff supervision with set up help for Activities of Daily Living (ADLs). The Quarterly Care Plan, dated 12/20/2019, instructed staff to provide positive interactions with the resident and anticipate and meet the resident's needs. On 03/09/2020 at 02:00 PM, observation revealed the resident in an art activity talked and laughed with other residents during activity. On 03/11/2020 at 08:54 AM, Licensed Nurse (LN) K stated she usually gave residents the phone at the nurse's station and helped them dial out. LN K stated she thought there was a phone in the activity room for privacy but upon entering the activity room she verified there was no phone. On 03/11/2020 at 09:05 AM, Certified Nurse Aide (CNA) N stated normally if a resident wanted to call someone staff brought them to the nurse's station to use that phone. On 03/11/2020 at 11:50 AM, Administrative Nurse D stated the procedure for residents wishing to make a private call was to have the residents use the phone in the Social Service Admission Office. Administrative Nurse D verified she just talked to Social Services to get the phone in the activity room fixed, there used to be one there but it was broken. On 03/11/2020 at 02:47 PM, LN L stated she would have R12 use the phone at the nurse's station to call and if R12 wanted privacy she would try to make sure no one was around. The facility's undated Resident's Rights policy documented residents have the right to have reasonable access to use of a telephone and a place in facility where calls could be made without being overheard including the right to retain and use a cellular phone at resident's own expense. The facility failed to provide a place for resident R12's telephone use, placing the resident at risk for lack of privacy.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. Based on observation and interview, the facility failed to provide a safe/clean/comfortable environment for two residents on the East hall when two recliners were in disrepair. Findings included: - On 03/08/2020 at 03:36 PM, observation revealed room [ROOM NUMBER]'s recliner with top layer of fabric missing approximately 3 inches (in) x 3 in on the arms, approximately 12 in x 12 inches in the seat, and numerous missing areas of different sizes on the back and across the footrest, with rough and uneven edges. On 03/08/2020 at 02:46 PM, observation revealed room [ROOM NUMBER]'s recliner with worn top layer of fabric missing on the outer surface, approximately 2 in x 3 in of the recliner arms, approximately 12 in x 12 in on the seat, an area approximately 0.25 in x 3 in on the back and numerous areas of different sizes on the footrest. On 03/11/2020 at 10:22 AM, Maintenance Staff (MS) V verified the above findings, stated the recliners were the residents' personal recliners, and the facility did not keep extra recliners because they had no place to store them. MS V stated the facility would order new recliners for the residents. Upon request, the facility failed to provide an environmental policy. The facility failed to provide clean, comfortable, undamaged recliners in two resident rooms, placing the residents at risk for injury.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to provide a baseline skin care plan for Resident (R) 166, who admitted to the facility with wounds on her buttocks. Findings included: - R166's medical record documented the facility admitted the resident on 03/04/2020. R166's Admission Minimum Data Set (MDS) in progress. The Baseline Care Plan, dated 03/04/2020, documented the resident had no skin issues. The Hospital Transfer Sheet to the facility, dated 03/03/2020, documented the resident had two small bilateral buttock pressure ulcers . The Nurse's Admission Summary Note, dated 03/04/2020, documented the facility admitted the resident this afternoon at approximately 03:30 PM. The note documented the resident had two small abraded (scraping or rubbing away of a surface, such as skin, by friction) areas (one to the left buttock and one to the right buttock), staff cleansed the areas, and treatment ordered. The Admission Skin Assessment, dated 03/04/2020, documented skin normal for ethnic group, warm, dry, and normal skin turgor. The assessment documented the resident's right buttock abraded area measured 0.2 centimeters (cm) x 0.2 cm and left buttock abraded area 0.3 cm x 0.2 cm. The Physician Order, dated 03/04/2020, directed staff to cleanse the abraded areas to the resident's buttocks and pat dry. The order directed staff to apply sure prep, allow to dry, then apply [MEDICATION NAME] (opaque dressing for wounds that is biodegradable, non-breathable, and adheres to the skin) dressing every three days and as needed until healed. The order directed staff to check placement of the resident's buttocks dressings every shift and replace as necessary. The Nutrition Progress Note, dated 03/06/2020, documented shearing (ragged and uneven in shape) to the resident's right buttock measured 0.2 cm x 0.2 cm and left buttock shearing 0.3 cm x 0.2 cm. On 03/11/2020 at 01:13 PM, observation revealed Licensed Nurse (LN) I entered the resident's room and explained the procedure. Observation revealed LN I applied gloves, asked the resident to turn on her left side, and assisted the resident pull down her incontinent brief and pants. LN I placed a clean towel underneath the resident on her right side, applied wound wash to both wounds, then removed the resident's dressings. Observation revealed an open area on the resident's right buttock and an open area on the left buttock without drainage or odor, and pink in color. Observation revealed LN I, wearing the same soiled gloves, sprayed the wounds with wound wash, then used gauze pads to clean the wounds and area around the wounds. Continued observation revealed LN I, wearing the same soiled gloves, applied skin prep around the wounds, waited until area dried, applied new dressings to the wound areas, then removed and discarded gloves. On 03/11/2020 at 02:03 PM, Administrative Nurse D stated when a resident was admitted to the facility with any kind of skin issue, a skin care section should be placed on the baseline care plan. The facility's undated Baseline Care Plan policy documented the facility would develop an initial person-centered care plan within the first 48 hours of admission for every resident. The baseline care plan would provide instructions for care of the resident. The facility failed to provide a baseline skin care plan for R166, when the facility admitted the resident with two wounds on her buttocks, placing the resident at risk for inappropriate skin care.
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 62 residents. The sample included 16 residents with three residents reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observation, interview, and record review, the facility failed to provide care and services to promote healing and prevent infection for one of three sampled residents, Resident (R) 117 who admitted with two pressure ulcers and developed infection in one pressure ulcer. Findings included: - R117's Admission Minimum Data Set (MDS), dated [DATE], documented the resident cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. The MDS documented the resident required extensive staff assistance with all Activities of Daily Living (ADL), at risk for pressure ulcers and had two unstageable (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (dead tissue, usually cream or yellow in color) or eschar (dead tissue) in the wound bed) pressure ulcers present on admission. The MDS documented the resident used pressure relief devices to chair and bed, and received nutrition, and pressure ulcer care. The Skin Care Plan, dated 02/21/20, directed staff to assess the resident for a history of pressure ulcers, provide current treatment per orders, and weekly document the pressure ulcer's stage, length, width, depth, odor, and progress or lack of progress. The care plan directed staff to offer the resident frequent repositioning and offloading, and licensed nurse to weekly assess and document changes in skin condition. The Admission Nursing Assessment, dated 02/18/20, documented pressure ulcer to R117's left shoulder measured 3.5 centimeter (cm) x 5 cm and left hip measured 6 cm x 3 cm. The physician's orders [REDACTED]. The Skin Note, dated 02/25/2020 at 04:43 PM, documented the resident's left shoulder pressure area measured 4.3 cm x 3 cm x 0.2 cm. Wound covered with black eschar and no drainage or foul smell. The Skin Note, dated 02/25/2020 at 09:00 PM, documented the resident's left hip pressure area measured 4.7 cm x 5 cm, with black eschar, no drainage or foul smell. The February 2020 Treatment Administration Record (TAR), documented Santyl treatment to the resident's left shoulder and hip not completed 02/24, 02/25, and 02/27. The Skin Assessment, dated 03/05/2020, documented the resident's left shoulder pressure ulcer measured 3 cm x 5.4 cm and left hip pressure ulcer measured 5 cm x 4.5 cm. No assessment for color, warmth, drainage or odor of the wound documented. The Skin Note, dated 03/06/2020 at 07:54 AM, (10 days later) documented the left shoulder pressure ulcer with black eschar measuring 4.3 cm x 2 cm x <0.2 cm, peri- wound blanchable (to press on a person's skin to push blood away and wait for return to determine blood circulation) and intact with no drainage or foul smell noted. Left hip pressure ulcer assessment revealed the treatment was in place but came off around edges. The note documented the resident rubbed the area at times due to itching. The wound revealed greenish/yellow drainage on the covering with a foul smell, wound measured 5 cm x 3.5 cm, periwound blanchable and red, and staff notified the physician. The Skin Note, dated 03/08/2020 at 03:33 PM, documented staff notified the physician of green drainage from wound, awaited return call. The Skin Note, dated 03/08/2020 at 04:29 PM, documented staff received new orders for a one time dose of [MEDICATION NAME] (antibiotic) 750 milligrams (mg) and obtain swab for bacterial culture of hip wound. On 03/11/2020 at 08:17 AM, observation revealed Licensed Nurse (LN) I provided wound care to R117's left hip pressure ulcer. LN I removed the soiled dressing, wound measured 4.5 cm x 4.5 cm, and area round with moist yellow slough around a dried yellowish center. LN I applied wound cleanser, changed gloves, and applied Santyl ointment. LN I applied Opti lock (non-adhesive super absorbent dressing) and secured the dressing with paper tape. On 03/11/2020 at 03:10 PM, observation revealed LN I provided wound care to R117's left shoulder pressure ulcer left open to air. LN I applied sure prep (moisture barrier) to right shoulder pressure ulcer, now covered with black eschar and measured approximately 2 cm diameter. On 03/10/2020 at 07:32 AM, LN LL stated he changed the resident's wound dressing twice daily, at the beginning of day shift and at the beginning of night shift. On 03/11/2020 at 10:27 AM, LN G stated staff measured wounds weekly and the assessments should be on the weekly skin assessments. LN G verified staff had not completed weekly skin assessments and the period of 10 days in between assessments was when the infection started. LN G verified staff had not documented daily pressure ulcer treatment in February as physician ordered. On 03/11/2020 at 11:15 AM, Certified Nurse Aide (CNA) N stated staff assisted the resident from bed to chair in the morning for therapy and after lunch to his recliner. On 03/11/2020 at 01:30 PM, Administrative Nurse D verified staff should perform weekly skin assessments, provide wound treatments as ordered, and document. The facility's undated Pressure Ulcer Management policy documented a licensed nurse would perform a full body skin assessment on the day of admission to the facility and weekly. An immediate plan to reduce a resident's risk of pressure ulcers or to treat an existing pressure ulcer will be developed and implemented. The facility failed to weekly assess R117's pressure ulcers and he developed an infection in his left hip pressure ulcer, placing the resident at risk for complications resulting from infection.
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 62 residents. The sample included 16 residents with one reviewed for urinary catheter. Based on observation, interview, and record review, the facility failed to provide care and services to prevent urinary tract infection (UTI-infection that occurs when bacteria enters into any part of the urinary tract) for Resident (R) 1 when providing cares and during transfers. Findings included: - R1's Physician order [REDACTED]. The Quarterly MDS, dated [DATE], documented the resident cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. The MDS documented the resident required extensive staff assistance with toileting and personal hygiene and a urinary catheter. The Urinary Care Area Assessment (CAA), dated 11/24/19, documented the resident had a urinary catheter related to a [DIAGNOSES REDACTED]. The Catheter Care Plan, dated 11/29/19, directed staff to assess the resident for use of a leg bag (discreet urine collection bag) if indicated, monitor and document for pain or discomfort due to the catheter, and change the catheter as needed. The care plan directed staff to monitor, record, and report to the physician any signs or symptoms of UTI, provide catheter care to prevent UTI, a privacy bag to cover the drainage bag at all times, and urology referral as indicated. The Progress Note, dated 11/21/19 at 04:16 AM, documented the resident had no urinary output this shift, abdomen assessed, resident stated she felt no urge to urinate and denied discomfort, even with palpation. The Progress Note, dated 11/21/19 at 09:54 PM, documented the nurse called the physician regarding minimal urine output this shift, the physician gave a verbal order to insert a urinary catheter, and set up a urology consult. The physician's orders [REDACTED]. The Progress Note, dated 03/09/2020 at 10:41 AM, documented staff notified the physician the resident with purulent (producing or containing pus) yellow vaginal drainage, and awaited a return call. The Progress Note, dated 03/09/2020 at 12:42 PM, documented staff received new orders for a Urinary Analysis (UA) with culture and sensitivity lab (examination of urine for bacteria and abnormalities with determination of which antibiotics should be used). The Urinary Analysis, dated 03/09/2020, documented 3+ bacteria (0 is normal). The Progress Note, dated 03/10/2020 at 09:24 AM, documented staff faxed the Urinary Analysis results to the physician for further instructions. On 03/10/2020 at 11:22 AM, observation revealed the resident in bed, two staff used a total lift (mechanical device used to transfer a resident unable to participate with transfers) to transfer the resident to a wheelchair. Certified Nurse Aide (CNA) N laid the catheter collection bag on the resident's abdomen during the transfer. Observation revealed no leg strap (fabric band or pouch that goes around the leg to comfortably secure the urinary drainage tubing) on the catheter tubing. On 03/10/2020 at 04:22 PM, observation revealed the resident in bed, stated sometimes the catheter tubing was pulled and some staff applied a leg strap, others don't know what a leg strap is. Observation revealed the catheter bag and tubing with slightly cloudy, dark yellow urine. CNA P placed the catheter bag in a privacy bag and hung it on the bed frame. On 03/11/2020 at 11:28 AM, observation revealed CNA N emptied the catheter collection bag into a container on the bare floor. CNA N did not disinfect the catheter collection bag port prior to or after emptying the bag. Observation revealed CNA N emptied the container of urine into the toilet, rinsed and placed the container on the back of the toilet, removed her gloves and washed her hands. CNA N verified she should have wiped the port with an alcohol wipe but there were not any in the room. On 03/10/2020 at 04:30 PM, CNA P stated staff emptied the catheter bag in the morning, checked it after meals, and at the end of their shift. CNA P stated every time staff changed the incontinence brief, staff also cleaned the tubing and peri area with clean wipes. CNA P stated some residents do not like the leg straps, but he could not remember if R1 refused the leg strap. On 03/11/2020 at 10:52 AM, Licensed Nurse (LN) G stated staff offered residents a catheter leg strap, but not all residents liked them. LN G stated staff were to perform catheter care every shift and as needed. On 03/11/2020 at 01:30 PM, Administrative Nurse D stated staff offered residents with urinary catheters a leg strap. Administrative Nurse D verified staff were to use an alcohol wipe on the port when emptying the collection bag and not elevate the catheter collection bag higher than the resident's bladder. The facility's Urinary Catheter Care policy, dated 11/20/13, did not include direction regarding handling and emptying of the collection bag or the use of leg straps. The facility failed to keep the urinary catheter bag below the level of the resident's bladder during transfer, failed to disinfect the port when emptying the collection bag, and failed to offer R1 a leg strap to prevent unnecessary pulling on the catheter tubing, placing the resident at risk for infection and discomfort.

F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility staff failed to administer appropriate amount of water flushes after every medication administered per Gastrostomy tube ([DEVICE] - a tube placed directly into the stomach for long-term enteral feeding) for Resident (R) 34. Findings included: - R34's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had short- and long-term memory problems and severely impaired cognition. The MDS documented the resident required total staff assistance with transfers and eating, functional limitation in range of motion on one side in upper and lower extremities, and had a [DEVICE]. The [DEVICE] Care Plan, dated 02/05/2020, instructed staff to check [DEVICE] placement and residual prior to use, administer medications, and flush as physician ordered. The Physician Order, dated 07/15/19, instructed staff to mix each individual crushed medication with 5-15 cubic centimeters (cc) of water to dissolve and flush with 15 cc of water in between each medication administration. On 03/10/2020 at 12:00 PM, during medication administration per [DEVICE], observation revealed Licensed Nurse (LN) LL flushed 30 cc of water after each individual medication. On 03/10/2020 at 12:20 PM, LN LL stated he always followed the same procedure as above when administering medications per the resident's [DEVICE]. On 03/11/2020 at 11:59 AM, Administrative Nurse D stated she expected staff to follow physician orders [REDACTED]. The facility's undated Administration of Medications Via a Gastrostomy Tube policy documented all medications would be administered to every resident as ordered by a physician in a safe and sanitary manner. The facility staff failed

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) to follow physician orders [REDACTED].
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. The sample included 16 residents with five reviewed for medications. Based on observation, interview, and record review, the facility failed to provide interventions to keep Resident (R) 28's oxygen saturation (measure of how much oxygen the blood carried as a percentage of the maximum it could carry) 94% or below, per physician orders. Findings included: - R28's Electronic Medical Record under [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. The resident required supervision with eating, limited staff assistance with mobility and toileting, and required extensive staff assistance with transfers, dressing, and toilet use. The MDS documented the resident received antianxiety (medication to treat mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), diuretic (medication to promote the formation and excretion of urine), and oxygen. The Care Plan, dated 0[DATE], directed staff to monitor the resident's vital signs as ordered, record, and notify the physician of significant abnormalities, and administer oxygen per physician orders. The care plan documented the resident had a history of [REDACTED]. The care plan directed staff to ensure the resident's oxygen level no higher than 94%, monitor oxygen saturation levels per order, and notify the physician if resident had low oxygen saturation, went into respiratory distress, or shortness of breath. The Physician Order, dated 08/19/19, directed staff to ensure the resident's oxygen saturation no higher than 94% and decrease oxygen if level greater than 94% every shift. The (NAME)2020 Oxygen Level documentation lacked checks on the following days: 03/01 day shift 03/02 night shift 03/03 evening shift 03/05 day shift 03/06 day shift 03/07 night shift 03/08 evening shift The January 15, 2020 - (NAME)10, 2020 Oxygen Levels documented the following: 01/15 98%, 96% 02/01 96%, 97%, 97% 02/02 98% 02/04 95% 02/06 95%, 95% 02/07 97% 02/18 97% 02/22 96% 03/07 95% x 2 03/10 97% x 2 The medical record lacked documentation of interventions regarding the higher than parameter oxygen saturation levels from 01/15/20 to 03/09/20. On 03/10/2020 at 08:00 AM, observation revealed Licensed Nurse (LN) K administered medications to the resident. Observation revealed the nurse stayed in the room until the resident swallowed the medication, and the resident wore an oxygen nasal canula. On 03/11/2020 at 10:52 AM, LN G stated staff were to ensure the resident's oxygen saturation was 94% or less. LN G stated staff monitored the level closely, and if needed, lowered her oxygen rate. LN G verified the missing documentation of oxygen levels. On 03/11/2020 at 11:15 AM, Certified Nurse Aide (CNA) N stated she obtained daily vital signs, including the resident's oxygen level. CNA N stated an oxygen saturation of 97% was good and she would not inform the nurse. CNA N stated nursing had not informed her of the order to keep this resident's oxygen level 94% or below. On 03/11/2020 at 01:30 PM, Administrative Nurse D verified staff were to document interventions when adjustments were made related to the resident's oxygen due to oxygen levels >94% as physician ordered. The facility's Physician order [REDACTED]. The facility's undated Administration of Oxygen policy documented oxygen therapy would be administered or supplied on prescription from the elder's physician and would be administered as prescribed with full details recorded in each elder's clinical record. The assessment guidelines included: measurement of oximetry level, rate, rhythm, and quality of respirations. The facility failed to provide R28 intervention, as physician ordered, when her oxygen level exceeded 94%, placing the resident at risk for respiratory complications.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 62 residents. Based on observation, record review, and interview, the facility failed to store and prepare food in accordance with professional standards for food service safety in one of one facility kitchen. Findings included: - On [DATE] at 10:27 AM, during initial tour of the kitchen, observation revealed the following undated or expired foods: Refrigerator 1 - four undated small bowls of gelatin - one small bowl of gelatin, dated ,[DATE] Refrigerator 2 - one zip lock bag with red sauce and meatballs, dated ,[DATE] - tomatoes on top shelf in box, dated ,[DATE] - vanilla pudding in plastic container with plastic wrap loosely placed over top partially covering container with 5 written on plastic wrap - one plastic four-quart container, dated ,[DATE] labeled pot & ham containing mashed potatoes on the bottom half covered by multiple ham slices Freezer 1 - one undated zip lock bag containing freezer burnt battered cooked chicken strips labeled Chick 9 On [DATE] at 10:45 AM, during tour of the kitchen during noon meal, observation revealed Dietary Staff (DS) CC washed hands, applied gloves, touched the counter, stove, refrigerator, then with the same soiled gloves placed sliced bread and cheese onto the grill. At 11:30 AM, observation revealed DS CC washed hands, put on gloves, touched the steam table, countertop, then with the same soiled gloves took a grilled cheese sandwich from the steam table and placed it on a resident's plate. On [DATE] at 10:27 AM, DS BB stated the four undated bowls of gelatin should have each been dated, the zip lock bag of red sauce and meatballs dated ,[DATE] should have been discarded, and the tomatoes in a box dated ,[DATE] should have been dated for ,[DATE] when they came in. DS BB stated the vanilla pudding was not covered and should have a full date written on it and the frozen chicken strips should have a correct date. DS BB discarded the gelatin, meatballs and red sauce, vanilla pudding, and frozen chicken strips, then wrote the correct date on the box of tomatoes. On [DATE] at 12:48 PM, DS DD verified the container with mashed potatoes covered with slices of ham should not be stored together and discarded them. On [DATE] at 11:45 PM, DS CC verified she should not have used the same gloves when she prepared and plated the grilled cheese sandwiches. The facility's undated Dietary Purchases, Receipt and Storage policy documented all products would be labeled with the date received in the facility and all products would be stored in a separate area. The facility failed to store and prepare food in accordance with professional standards for food service safety, placing the 60 residents who received food from the facility kitchen at risk for food borne illness.
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 62 residents. The sample included 16 residents. Based on observation, record review, and interview, the facility failed to use appropriate infection control guidelines for laundry services, housekeeping services, wound care for Resident (R) 166, and contact isolation for [MEDICAL CONDITION] ([MEDICAL CONDITION]-a contagious bacteria characterized by foul smelling frequent bowel movements) for R52. Findings included: - On 03/10/2020, at 09:35 AM, observation of West Hall room [ROOM NUMBER] revealed clear to slightly yellow/pink tinged fluid on the fitted be sheet and green blanket at the foot of the bed. On 03/10/2020 at 01:43 PM, observation of West Hall room [ROOM NUMBER] revealed a clear plastic sack containing a bed linen with yellow/pink drainage and green blanket resting on the floor between the foot of the bed and dresser. On 03/01/2020 at 09:22 AM, observation of West Hall room [ROOM NUMBER] revealed a clear plastic sack containing a bed linen with yellow/pink drainage and green blanket resting on the floor between the foot of the bed and dresser. Further observation revealed soiled dressings in the open trash container under the bed-side table with the resident's breakfast tray on the bedside table. On 3/11/2020 at 09:22 AM, Licensed Nurse (LN) J stated she had not placed used soiled dressings into the trash and did not know when the dressings were removed or changed. LN J verified the trash and sack containing the soiled bed sheet and blanket should have been removed immediately once the staff was finished in the room. On 3/11/2020 at 09:43 AM, Administrative Nurse D verified trash and soiled linens should have been removed from the room immediately after staff were finished in the room. The facility's Infection Control policy, dated 01/01/2020, documented standard and transmission-based precautions should be followed to prevent the spread of infection. The facility failed to remove soiled wound dressings, bed linens, and blanket from West Hall room [ROOM NUMBER] placing the resident at risk for infection. - On 03/11/2020 at 01:13 PM, observation revealed LN I entered Resident (R) 166's room and explained the procedure. Observation revealed LN I applied gloves, asked the resident to turn on her left side, and assisted the resident to pull down her incontinent brief and pants. LN I placed a clean towel underneath the resident on her right side, applied wound wash to both resident wound dressings, then removed the resident's dressing. Observation revealed an open area on the resident's right buttock and an open area on the left buttock without drainage, odor, and pink in color. Observation revealed LN I, wearing the same soiled gloves, sprayed the wounds with wound wash, used gauze pads to clean the wounds and area around the wounds. Continued observation revealed LN I, wearing the same soiled gloves, applied skin prep around the wounds, let it dry, applied new dressings to the wound areas, then removed and discarded gloves. On 03/11/2020 at 01:33

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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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 3) PM, LN I stated she should have removed her gloves between removing the old dressing and applying the new dressing. On 03/11/2020 at 02:03 PM, Administrative Nurse D stated staff should change gloves between dirty and clean when providing a dressing change. The facility's Infection Control policy, dated 01/01/2020, documented when procedures require gloves to be worn for removing a dressing, hands are washed, and clean nonsterile disposable gloves are worn. After removal of dressing, remove gloves. If hand surfaces had not been contaminated, the clean or sterile gloves for performing the procedure may immediately be donned. The facility staff failed to change gloves after removing a soiled wound dressing and before applying a new dressing, placing the resident at risk for receiving an infection. - Resident (R) 52's Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired cognition with a Brief Interview for Mental Status (BIMS) score of 10. The MDS documented the resident required extensive assistance of two staff with bed mobility, transfers, dressing, toilet use, and always incontinent of urine and bowel. The Cognition Care Area Assessment (CAA), dated 01/22/2020, documented the resident with cognitive loss related to BIMS score of 10 and required extensive to total staff assistance with Activities of Daily Living (ADLs). The Incontinence Care Plan, dated 01/30/20, lacked staff direction for care of [MEDICAL CONDITION]. The care plan directed staff to check the resident for incontinence every two hours, assist with toileting as needed, provide loose fitting easy to remove clothing, and provide peri-care after each incontinent episode. The Infectious Disease Consult Report, dated 01/09/20, documented blood cultures obtained and Empiric [MEDICATION NAME] (antibiotic) and [MEDICATION NAME] (antibiotic) started. Staff repeatedly treated the resident with [MEDICATION NAME] (antibiotic) (most recently around Christmas). The report documented the resident received [MEDICATION NAME]/tazobactam (antibiotic) in the hospital, tolerated the therapy, and had a diarrhea and fecal management system. The Hospital Transfer Sheet, dated 01/17/20, documented the resident had no [MEDICAL CONDITION] infection at that time and discharged to the facility. The Emergency Department Report, dated 02/09/2020, documented the stool specimen lab test for [MEDICAL CONDITION] indicated presumptive negative and positive A* with a [DIAGNOSES REDACTED]. diff and [DIAGNOSES REDACTED] toxin are positive, it is likely that the person's diarrhea and related symptoms are due to the presence of toxin-producing [DIAGNOSES REDACTED]. A positive result for [DIAGNOSES REDACTED] bacteria or [DIAGNOSES REDACTED] [MEDICATION NAME] but a negative [DIAGNOSES REDACTED] toxin result means that the bacteria are present in the digestive tract but are not producing a detectable level of toxin. Negative test results for both the bacteria and the toxin may mean that the diarrhea and other symptoms are being caused by something other than [DIAGNOSES REDACTED].) The Readmission orders [REDACTED]. On 03/08/2020 at 12:30 PM, observation revealed R52's family member propelled him in his wheelchair from the dining room to his room at the far end of the hall. No contact precautions were observed in place. On 03/09/2020 at 04:18 PM, observation revealed the resident in his recliner, stated staff did not have him wash his hands prior to leaving his room, and he still had some diarrhea. Observation revealed the resident's family member placed her coat on the resident's bed footboard, her purse on his bed, and did not wear an isolation gown or gloves while in his room. At 04:20 PM, observation revealed CNA Q and CNA R, wore isolation gowns and gloves, used the total lift and transferred the resident from his wheelchair to his bed. Observation revealed the CNAs provided proper incontinent care after the resident had a small smear of bowel. Observation revealed the CNAs transferred the resident back to his wheelchair and left the lift sling under the resident. Observation revealed the CNAs removed their isolation gowns/gloves, washed their hands, took the red biohazard trash bag to the soiled utility, placed in a red trash bin, and washed their hands. Observation revealed the CNAs brought the lift out of the room into the hall and cleaned it with micro kill bleach wipes. On 03/09/2020 at 04:47 PM, observation revealed Restorative Aide (RA) S entered R52's room and sat in the resident's recliner without wearing a protective gown or gloves. RA S assisted the resident with restorative exercises and placed weights on the resident's legs and in his hands. RA S exited the room without washing her hands or the hand/leg weights, placed the weights on top of the isolation cart, and asked the nurse for bleach wipes. RA S carefully wiped the weights, placed the weights back on the therapy rack, and picked up other equipment to do restorative exercises with R1, still wearing the contaminated uniform. On 03/09/2020 at 11:54 AM, CNA Q stated R52 had [MEDICAL CONDITION] and contamination was through bowel contact. On 03/09/2020 at 12:01 PM, CNA P stated the resident had [MEDICAL CONDITION] and staff were to wear gloves, gown, and occasionally a mask when caring for him. CNA P stated administration told them if the resident wanted to go out of their room to eat, that was their right. On 03/09/2020 at 01:20 PM, LN G stated as of Friday (3 days ago) the resident still had some loose stools. To control infection staff were to ensure the resident was clean and washed his hands prior to leaving his room. LN G stated the resident liked to eat in the dining room and was an aspiration (inhaling foreign material) risk. The facility offered to have staff sit in the resident's room while he ate, but his spouse and the resident refused, so he was allowed to eat in the dining room without any contact isolation measures. On 03/09/2020 at 03:00 PM, Administrative Nurse D stated the facility infection control policy was used to direct contact precautions for [MEDICAL CONDITION]. On 03/09/2020 at 03:28 PM, Administrative Nurse D stated the resident's 0[DATE] admission orders [REDACTED]. Administrative Nurse D stated only one resident at a time with [MEDICAL CONDITION] was transported to [MEDICAL TREATMENT] or other appointments and verified the care plan should include contact isolation directions. On 03/09/2020 at 03:44 PM, Dietary Staff (DS) BB stated staff used soap and water then sanitizer, Betco sanibet-ammonium (non-bleach sanitizer) to clean tables. DS BB stated staff usually placed a tablecloth on each table for meals. DS BB stated staff did not use bleach to disinfect tables or chairs. DS BB verified disposable plates and silverware were not provided for R52 to use. On 03/10/2020 at 07:25 AM, Housekeeping Staff (HS) W stated she used Betco AF 79 (ammonium) disinfectant to spray surfaces in the contact isolation rooms. HS W verified staff did not use a bleach solution during cleaning of [MEDICAL CONDITION] isolation rooms, was aware the resident had [MEDICAL CONDITION], and was in contact isolation. Betco AF79 guidelines documented it did not kill [MEDICAL CONDITION]. On 03/10/2020 at 08:01 AM, Housekeeping Staff (HS) U, reported laundry used Betco laundry products to disinfect linens/laundry from residents in isolation with [MEDICAL CONDITION] . On 03/10/2020 at 12:01 PM, Administrative Staff A verified the Betco disinfectant did not kill [MEDICAL CONDITION]. On 3/10/2020 at 12:47 PM, Administrative Staff A, provided a Material Safety Data Sheet (MSDS) for Betco White Cap Destainer (powerful peroxide based destainer deodorizes fabrics and boosts cleaning, removing difficult stains without degrading whites and colorfast fabrics) used by the facility which contained sodium hypochlorite (a compound that can be effectively used for water purification. It is used on a large scale for surface purification, [MEDICATION NAME], odor removal and water disinfection). The MSDS recommended use to remove organic stains, did not contain information regarding use in laundry for disinfecting [MEDICAL CONDITION]. The MSDS information lacked documentation of use to disinfecting [MEDICAL CONDITION]. On 03/11/2020 at 10:27 AM, LN G stated staff placed the resident in isolation on 0[DATE] per report from hospital, the unit manager or nurse who took the report notified all staff of the isolation by sending out a mass notification verbally or by text, and was unsure why dietary did not provide disposable plates and silverware. The facility's undated Preventing Spread of [MEDICAL CONDITION] policy documented staff would wear clean, non-sterile gloves and gown when entering the room of a resident infected with [MEDICAL CONDITION]. Gloves and gowns should be removed before leaving the resident's room and hands immediately washed with an antimicrobial soap. The facility's undated Infection Control policy documented the facility would facilitate safe care of all residents and staff with known or suspected communicable disease by maintaining an infection control program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Infection Control Program would follow accepted national standards. Residents with known or suspected communicable disease would be placed in isolation precautions consistent with CDC recommendations and guidelines and with the order of the primary care physician. All staff including physicians, nursing staff, social services, laundry, dietary, activity, volunteers, environmental, and all other facility employees are responsible for complying with isolation precautions and for reporting observed variances of the policy to the attention of any person not following the policy. During transports of residents in isolation, no other resident will be transported at the same time and appropriate and thorough cleaning of all transport vehicles would be performed and documented using EPA approved sanitizing agents approved for the specific microorganism identified. All wheelchairs and other assuasive devices would be cleaned thoroughly using EPA approved sanitizing agents approved for the specific microorganism identified. The nurse and or physician would thoroughly explain the isolation precautions to the resident and responsible party and will encourage compliance with the precautions. At no time would the resident be allowed to place other residents, staff or visitors in jeopardy related to non-compliance. Contact Precautions: private room, wear clean gowns, gloves when entering the room and wash hands immediately with antimicrobial soap before leaving the isolation room. Ensure clothing does not contact potentially contaminated surfaces. Limit movement and transportation of resident from the room to essential purposes only. When resident is transported ensure precautions are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175200	A. BUILDING _____ B. WING _____	**03/11/2020**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) maintained. The facility failed to follow infection control guidelines for R52, who had[DIAGNOSES REDACTED], placing other residents in the facility at risk for infection.