STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175457	A. BUILDING _____ B. WING _____	**06/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEABODY HEALTH AND REHAB	**407 N LOCUST STREET PEABODY, KS 66866**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents, with three residents sampled. Based on observation, interview and record review, the facility failed to utilize proper infection control techniques when caring for a suprapubic catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) for one sampled Resident (R) 4, while providing cares, and failed to prevent the urinary catheter collection bag from lying on the floor without a barrier. Findings included: - The Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the staff assessment for cognition revealed moderately impaired cognition. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and required extensive assistance of two staff for toilet use. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA), dated 01/01/2020, documented the resident had an indwelling urinary catheter. The quarterly MDS, dated [DATE], documented the staff assessment for cognition revealed moderately impaired cognition. The resident had an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag) and required total assistance of two staff for toilet use. On 06/23/2020 at 01:09 PM, Certified Nurse Assistant (CNA) M, entered R4's room to empty his urinary catheter collection bag. CNA got a urinal out of the resident's bathroom, dated 06/21/2020, indicating the urinal had been used for two days by the staff. CNA then unclipped the tubing and began to drain the urine in the collection bag into the urinal, touching the inside of the dirty urinal with the tip of the tubing. Following the emptying of the urine collection bag, CNA reattached the tubing to the urine bag without cleaning the tip of the tubing with an alcohol wipe. On 06/23/2020 at 01:10 PM, CNA M, stated this was the technique she always used when emptying catheter collection bags. On 06/23/2020 at 03:45 PM, Administrative Nurse D, stated the tip of the catheter tubing should never come into contact with the urinal when staff drained the urine from the collection bag. The facility policy for Indwelling Urinary Catheters, effective 01/2020, documented staff should prevent contact of the drainage spigot with the nonsterile container. The facility failed to prevent the drainage spigot of the urinary catheter tubing from coming into contact with the unclean container used to collect the resident's urine resulting in cross contamination. Furthermore, on 06/23/2020 at 01:09 PM, Certified Nurse Assistant (CNA) M, entered R4's room to empty his urinary catheter collection bag. Upon completion of the cares, CNA M placed the empty catheter collection bag directly on the floor without a barrier. On 06/23/2020 at 01:10 PM, CNA M stated staff keep the resident's catheter collection bag directly on the floor without a barrier as the resident would remove the dignity bag. On 06/23/2020 at 03:45 PM, Administrative Nurse D stated the urinary collection bag should have some sort of barrier and not rest directly on the floor. The facility policy for Indwelling Urinary Catheters, effective 01/2020, documented staff should ensure the catheter tubing and drainage bag were kept off of the floor. The facility staff failed to prevent the urinary catheter collection bag from coming into direct contact with the floor.

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.