STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SMITH CENTER HEALTH AND REHAB	**117 W 1ST STREET #369 SMITH CENTER, KS 66967**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents. Based on record review and interview, the facility failed to notify the physician for one unsampled resident Resident (R) 45's decreased oxygen saturation level. Findings included: - R45's Physician order [REDACTED]. fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred), and interstitial lung disease (disorder that causes progressive scarring of lung tissue). The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired cognition, required extensive assistance of one staff for Activities of Daily Living (ADLs), used oxygen, and received occupational, physical, and respiratory therapy. The ADL Care Area Assessment (CAA), dated 04/19/20, documented the resident required assistance with ADL's due to shortness of breath, wore oxygen, and at risk for further decline. The [MEDICAL CONDITION] Care Plan, dated 06/09/20, documented the resident had [MEDICAL CONDITION] and readmitted to the facility on [DATE] for exacerbation of [MEDICAL CONDITION]. The care plan directed staff to monitor, document, and report to the medical doctor any signs or symptoms of congestive heart (shortness of breath upon exertion, cool skin, cough, weakness, crackles and wheezes upon listening to lung sounds, weakness, fatigue, lethargy, increased heart rate, and disorientation) and the resident received oxygen therapy at 5 liters continuously and 6 liters with activity. The POS, dated 06/09/20, directed staff to provide the resident oxygen therapy at 5 liters via nasal cannula, increase to 6 liters with activity, and may use oxygen mask for short time to help with shortness of air symptoms to keep oxygen levels above 90%. The orders directed staff to administer [MEDICATION NAME] sulfate nebulizer solution (breathing treatment) four times a day and every four hours, as needed, for shortness of breath. The Treatment Administration and Vital Sign Record, dated 06/14/20, recorded the following breathing treatments without follow-up assessment: 06:35 AM, oxygen saturation of 98% prior to treatment 11:04 AM, oxygen saturation of 95% prior to treatment 04:26 PM, oxygen saturation of 94% prior to treatment 08:25 PM, oxygen saturation of 81% prior to treatment The Nurse's Note, dated 06/14/20 at 08:25 PM, recorded treatment given as ordered, oxygen on at 6 liters via cannula, saturation at 81% and the resident rested in bed and voiced no complaints at that time. The Nurse's Note, dated 06/14/20 at 11:05 PM, recorded the resident lying on the floor in the doorway of the bathroom, prone (chest down, back up) with face turned to her left, no signs of circulation or respirations noted, and Do Not Resuscitate (DNR) on file. Review of R45's medical record lacked documentation staff notified the physician of R45's decreased oxygen saturation at 08:25 PM, or that staff further assessed the resident's condition. On 06/06/20 at 01:38 PM, Administrative Nurse D stated nursing staff should have reassessed R45's oxygen saturation levels and notified the physician if the saturation remained low. The facility's Change in Resident 's Condition or Status policy, dated January 2020, documented the Nurse Supervisor/Charge Nurse will notify the attending physician or on-call physician and resident's representative of a significant change in the resident's physical, mental, or psychosocial status in either life threatening conditions or clinical complications. The facility failed to notify R45's physician of the residents decrease in oxygen saturation, placing the resident at risk for further decline.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to provide a safe, clean, comfortable and homelike environment on two of four halls in the facility. Findings included: - On 08/03/20 at 10:10 AM, observation during initial tour revealed the following: Fluorescent light coverings above the north nurse's station contained numerous bugs. West Hall room [ROOM NUMBER] had multiple scratches and chunks out of the dry wall, approximately three inches by six inches, on the wall by a resident's bed and two unfilled holes. The front entrance nurse's station, outside the administrator's office, with approximately 10 feet (ft) x four ft area of buckled carpet. On 08/06/20 at 08:36 AM, during the environmental tour, Maintenance Staff (MS) U verified the above findings and stated the facility had plans to replace the carpet, but they had been put on hold because of the pandemic (outbreak of disease) and restriction on visitors. MS U stated if staff had any concerns, they were to place them in the notebook at the West nurse's station and he was unaware of the scratches and chunks out of the dry wall. The facility's Supervision, Maintenance policy, dated January 2020, documented the day to day maintenance operation is under the supervision of the maintenance director. The policy documented the administrator is responsible for the overall supervision of the maintenance department. The maintenance director is responsible for scheduling preventative maintenance service. The facility failed to provide a safe, clean environment, placing the residents at risk for accidents and an unclean environment.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents with three reviewed for behaviors. Based on observation, record review, and interview, the facility failed to address behaviors and the use of a leg immobilizer on the care plan for one of three sampled residents, Resident (R) 7. Findings included: - R7's Quarterly/Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired decision making skills and required extensive staff assistance with bed mobility, dressing, toileting, and personal hygiene. The assessment documented the resident had other behaviors daily, surgical wound care, and a nonsurgical dressing. The Behavior Care Area Assessment (CAA), dated 05/18/20, documented the resident moaned loudly and cried, staff contributed this more to discomfort and sadness then behavior. The CAA documented the resident was at risk for mood concerns related to pain and current condition. The Mood Care Plan, dated 07/23/20, documented the resident had a mood problem due to amputation of partial foot then above the knee due to complications. The care plan directed staff to assist the resident, family, and caregivers to identify and reinforce strengths, and positive coping skills. The care plan failed to document the resident's behavior of removing the dressings on her left [MEDICAL CONDITION] (BKA). The Skin Impairment Care Plan, dated 07/23/20, directed staff to monitor the resident's surgical wound for signs and symptoms of infection, notify the physician as needed, orient the resident as needed to the care regiment, current medical needs and interventions. The care plan failed to document the resident had a

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) full leg immobilizer (a brace to keep the leg straight and immobile). The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. when resident removed the dressing. (The order was obtained after this surveyor asked to see the order.) The physician's orders [REDACTED]. The order directed staff to cover the wound bed with 4 x 4's, silver alginate (a dressing that absorbs exudates and forms a gel-like covering over the wound), cover with Abdominal (ABD) gauze pad (absorbs drainage from wounds and roll gauze, then cover with an ACE bandage. The Nurse's Note, dated 07/20/20 at 02:48 PM, documented the facility readmitted the resident to skilled care after she had a BKA of the left leg. The note further documented the resident had a full leg immobilizor and an ACE wrap over her wound that was to remain in place until her physician appointment on 07/23/2020. The Nurse's Note, dated 07/24/20 at 06:40 PM, documented the resident pushed the leg immobilizer and dressing off four times during day shift. The note further documented staff applied loose fitting tubi grip (elastic bandage intended to aid recovery of an injured limb) over the wound and reapplied the leg immobilzer. The note documented the physician ordered a decrease in the resident's [MEDICATION NAME] to one tablet every eight hours as needed. The Nurse's Note, dated 07/29/20 at 08:40 PM, documented the resident removed the immobilizer and tried to remove the dressing. The note further documented staff readjusted the dressing, applied the immobilizer, and explained to the resident the immobilizer wound keep the dressing and wrap into place. The resident denied removing the immobilizer. The Nurse's Note, dated 07/30/20 at 12:01 PM, documented the resident pulled off the immobilizer and the dressing from her left leg stump. The note further documented staff covered the wound with ABD gauze pad, 4 x 4 gauze pad, secured the dressing with kling wrap, and reapplied the immobilizer. Staff asked the resident to leave the immobilizer and dressing on. The Nurse's Note, dated 07/31/20 at 09:00 PM, documented the resident removed the ace wrap to her dressing twice since 08:00 PM, and when staff checked on the resident, the dressing was completely off. The resident stated she did not remove the dressing. The Nurse's Note, dated 08/02/20 at 12:30 AM, documented staff reapplied the dressing of three ABD pads, a 4 x 4 gauze, and covered it with kling gauze, tape, and wrapped with an ACE wrap. The Nurse's Note, dated 08/02/20 at 05:41 PM, documented staff contacted the emergency room (ER)regarding the resident's pain and behaviors. The resident continued to cry out and removed the dressing off of her left leg wound. The note further documented the physician increased the resident's pain [MEDICATION NAME] to 20 mcg/hr every week, placed an additional 10 mcg/hr patch that day and directed staff replace both patches on 08/07/20. The Nurse's Note, dated 08/03/20 at 12:45 AM, documented the resident removed her wound dressing and staff reapplied the dressing. On 08/03/20 at 03:43 PM, observation revealed the resident in her recliner, footrest in the up position, resident's dressing loose and appeared the resident had pulled on the gauze wrap. Further observation revealed no leg immobilizer on the resident's left leg. On 08/04/20 at 01:13 PM, observation revealed the resident in her recliner, footrest in the up position, left leg immobilizer in place. On 08/05/20 at 01:28 PM, observation revealed the resident in her recliner, no dressing to her left leg wound, and a 4 x 4 with dried blood still stuck to the wound. On 08/05/20 01:45 PM, observation revealed Licensed Nurse (LN) H placed a bed pad under the resident left leg stump, cleansed the wound with wound cleanser, applied a 4 x 4 and ABD pad, wrapped the dressing with an ACE wrap, and applied the immobilizer to the resident's left leg. On 08/04/20 at 10:45 AM, LN G stated the resident frequently removed the dressing and staff had to redress the wound. LN G verified there was not an order from the physician to redress the wound. On 08/04/20 at 1:31 PM, Certified Nurse Aide (CNA) P stated the resident frequently removed the bandage on the wound and did not like when staff put the immobilizer on. On 08/04/20 at 03:00 PM, CNA Q stated staff tried to check on her more often and when the resident removed the bandage they told the nurse so the wound could be redressed. On 08/05/20 at 01:34 PM, LN H stated the resident removed the bandage multiple times a day and would say she didn't take it off. On 08/06/20 at 11:37 AM, Administrative Nurse D verified the resident's behaviors of removing the dressing and the leg immobilizer should have been on the care plan. The facility's Comprehensive Assessment, policy, dated January 2020, documented a comprehensive care plan would be developed within 14 days, and the comprehensive assessment would be used to develop, review and revise the resident's comprehensive care plan. The facility failed to identify and address R7's behaviors and the use of a leg immobilizer on her care plan, placing the resident at risk for inappropriate care.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents with two reviewed for nutrition. Based on observation, record review, and interview, the facility failed to accurately monitor one of two sampled residents fluid restriction, Resident (R) 195. Findings included: - R195's Admission Physician order [REDACTED].) The Admission Minimum Data Sheet (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented the resident required limited assistance of one staff for eating and extensive assistance of one to two staff with all other Activities of Daily Living (ADLs). The MDS documented the resident had difficulty or pain swallowing and received daily diuretic medication. The Nutrition/Hydration Care Plan, dated 08/03/20, instructed staff to provide R195 a 1500 milliliters (ml) in 24-hour fluid restriction and monitor the resident's daily intake and output. R195's admission orders [REDACTED]. Review of R195's Intake Records for 07/23/20-08/04/20 lacked fluid intake documentation on the following days: 07/23/20 07/24/20 07/25/20 07/26/20 07/27/20 07/30/20 07/31/20 08/03/20 08/04/20 On 08/04/20 at 11:37 AM, observation revealed a clear measured water pitcher with approximately 250 ml of clear fluid within reach on the resident's bedside table. On 08/05/20 at 08:58 AM, Certified Nurse Aide (CNA) N stated documentation of fluid intake and output was written on a paper copy at the nurse's desk for residents on fluid restrictions. CNA N stated nurse aides monitored and documented the fluid intake by entering the totals consumed from the water pitcher in the resident room at 1:45 PM, 9:45 PM and 5:45 AM, and nursing staff was responsible for the daily totals. CNA N stated she was sure all the amounts were written on the paper except the fluid intake from meals and the dietary aides logged the fluid intake from the meals into the computer for nursing staff to obtain. On 08/05/20 03:15 PM, CNA O stated fluid restrictions were monitored on the paper log at the nurse's desk, totals were written after visualizing what was in the water pitcher at the end of the shift, and meal fluid intake totals were added at the end of shift. On 08/05/20 04:00 PM, Licensed Nurse (LN) G stated R195 was on a strict fluid intake. LN G stated the end of the day totals were entered by the nurses and the dietary manager entered meal fluid intakes. LN G stated if there was a blank space in the documentation that meant staff failed to enter the fluid amounts that day. On 08/05/20 at 04:37 PM, LN G stated she entered the total meal fluid intake into the log based on the amounts allotted per meal on the Distribution of Fluids for Fluid Restriction as opposed to entering amount actually consumed by the resident. On 08/06/2020 08:40 AM, Administrative Nurse D verified the facility had two residents on fluid restrictions. Administrative Nurse D reported staff monitored fluid Intake by documenting and reviewing the paper intake log located at the nurse's desk. Administrative Nurse D stated the CNAs entered amount of fluid consumed on the log 15 minutes prior to the end of their shift, were responsible for documenting meal fluid intake, and a nurse was responsible for the totals at the end of the 24 hour period. Administrative Nurse D verified the intake log lacked documentation on the above days and agreed the procedure was not effective for monitoring fluid intake. The facility's Encouraging and Restricting Fluids policy, dated February 2020, documented the facility is to follow specific instructions concerning fluid intake or restrictions and be accurate when recording fluid intake. The policy documented to include the date and time the procedure was performed, the amount (in milliliters) of fluids consumed by the resident during the shift, and the type of liquid consumed. The facility failed to follow R195's fluid restriction order, placing the resident at risk for fluid overload.
F 0710 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to obtain a physician order [REDACTED]. Findings included: - R7's Quarterly/Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired decision making skills and required extensive staff assistance with bed mobility, dressing, toileting, and personal hygiene. The assessment documented the resident had other behaviors daily, received surgical wound care, and a nonsurgical dressing. The Behavior Care Area Assessment (CAA), dated 05/18/20, documented the MDS recorded the resident's behavior and was at risk for mood concerns related to pain and current condition. The Mood Care Plan, dated 07/23/20, documented the resident had a mood problem due

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F 0710 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) to amputation of the left partial foot then above the knee due to complications. The care plan directed staff to assist the resident, family, and caregivers to identify and reinforce strengths and positive coping skills. The care plan failed to document the resident's behavior of removing the dressings on her left [MEDICAL CONDITION] (BKE). The Skin Impairment Care Plan, dated 07/23/20, directed staff to monitor the resident's surgical wound for signs and symptoms of infection, notify the physician as needed, orient the resident as needed to the care regimen, current medical needs and interventions. The care plan failed to document the resident had a full leg immobilizer (a brace to keep the leg straight and immobile). The physician's orders [REDACTED].) as needed when resident removed the dressing. (The order was obtained after this surveyor asked to see the order.) The Nurse's Note, dated 07/20/20 at 02:48 PM, documented the facility readmitted the resident to skilled care after she had a BKA of the left leg. The note documented the resident had a full leg immobilizer and an ACE wrap over her wound that was to remain in place until her 07/23/20 physician appointment. The Nurse's Note, dated 07/24/20 at 06:40 PM, documented the resident pushed the leg immobilizer and dressing off four times during day shift. The note documented staff applied loose fitting tubi grip (elastic bandage intended to aid recovery of an injured limb) over the wound and reapplied the leg immobilzer. The note documented the physician ordered a decrease in the resident's [MEDICATION NAME] (narcotic pain medication) to one tablet every eight hours as needed. The Nurse's Note, dated 07/29/20 at 08:40 PM, documented the resident removed the immobilizer and tried to remove the dressing. The note documented staff readjusted the dressing, applied the immobilizer, and explained to the resident the immobilizer wound keep the dressing and wrap into place. The resident denied removing the immobilizer. The Nurse's Note, dated 07/30/20 at 12:01 PM, documented the resident pulled off the immobilizer and dressing from her left leg stump. The note documented staff covered the wound with Abdominal (ABD) gauze pad (absorbs drainage from wounds), 4 x 4 gauze, secured the dressing with kling wrap, and reapplied the immobilizer. Staff asked the resident to leave the immobilizer and dressing on. The Nurse's Note, dated 07/31/20 at 09:00 PM, documented the resident removed the ace wrap to her dressing twice since 08:00 PM, and when staff checked on the resident, the dressing was completely off. The resident stated she did not remove the dressing. The Nurse's Note, dated 08/02/20 at 12:30 AM, documented staff reapplied the dressing of three ABD pads, 4 x 4 gauze, and covered it with kling gauze, tape, and wrapped with an ACE wrap. The Nurse's Note, dated 08/02/20 at 05:41 PM, documented staff contacted the emergency room (ER) regarding the resident's pain and behaviors. The resident continued to cry out and removed the dressing off of her left leg wound. The note documented the physician increased the resident's [MEDICATION NAME] to 20 mcg/hr every week, placed an additional 10 mcg/hr patch that day and directed staff replace both patches on 08/07/20. The Nurse's Note, dated 08/03/20 at 12:45 AM, documented the resident removed her wound dressing and staff reapplied the dressing. On 08/03/20 at 03:43 PM, observation revealed the resident in her recliner, footrest in the up position, the resident's dressing loose and appeared the resident had pulled on the gauze wrap. Further observation revealed the resident did not have the leg immobilizer on her left leg. On 08/04/20 at 01:13 PM, observation revealed the resident in her recliner, footrest in the up position, left leg immobilizer in place. On 08/05/20 at 01:28 PM, observation revealed the resident in her recliner, no dressing to her left leg wound and a 4 x 4 with dried blood still stuck to the wound. On 08/05/20 01:45 PM, observation revealed Licensed Nurse (LN) H placed a bed pad under the resident's left leg stump, cleansed the wound with wound cleanser, applied a 4 x 4 and ABD pad, wrapped the dressing with an ACE wrap, and applied the immobilizer to the resident's left leg. On 08/04/20 at 10:45 AM, LN G stated the resident frequently removed the dressing and staff had to redress the wound. LN G verified there was not an order from the physician to redress the wound. On 08/04/20 at 1:31 PM, Certified Nurse Aide (CNA) P stated the resident frequently removed the bandage on the wound and did not like when staff put the immobilizer on. On 08/04/20 at 03:00 PM, CNA Q stated the staff try to check on the resident more often and when the resident removed the bandage they told the nurse so the wound could be redressed. On 08/05/20 at 01:34 PM, LN H stated the resident removed the bandage multiple times a day and would say she didn't take it off. LN H further stated she did not know what else they could try to keep the bandage on. On 08/06/2020 at 11:37 AM, Administrative Nurse D verified the order for redressing the residents wound after she would take it off was not obtained until 08/04/2020. The facility's Physician Services policy dated January 2020, documented the medical care of each resident was under the supervision of a licensed physician and orders for the resident's immediate care and needs would be provided by a physician, physician assistant, nurse practitioner, or clinical nurse specialist. The policy further documented the resident's attending physician was responsible for prescribing new therapy. The facility failed to obtain a physician order [REDACTED].
F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident must receive and the facility must provide necessary behavioral health care and services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents with three reviewed for mood and behaviors. Based on observation, record review, and interview, the facility failed to provide necessary behavioral health care and services to maintain mental and psychosocial well-being for one of three sampled residents, Resident (R) 7. Findings included: - R7's Quarterly/Medicare 5-Day Minimum Data Set (MDS), dated [DATE], documented the resident had moderately impaired decision making skills and required extensive staff assistance with bed mobility, dressing, toileting, and personal hygiene. The assessment documented the resident had other behaviors daily, received surgical wound care, and a nonsurgical dressing. The Behavior Care Area Assessment (CAA), dated 05/18/20, documented the MDS recorded the resident's behavior and at risk for mood concerns related to pain and current condition. The Mood Care Plan, dated 07/23/20, documented the resident had a mood problem due to amputation of the left partial foot then above the knee due to complications. The care plan directed staff to assist the resident, family, and caregivers to identify and reinforce strengths and positive coping skills. The care plan failed to document the resident's behavior of removing the dressings on her left [MEDICAL CONDITION] (BKA). The Skin Impairment Care Plan, dated 07/23/20, directed staff to monitor the resident's surgical wound for signs and symptoms of infection, notify the physician as needed, orient the resident as needed to the care regimen, current medical needs and interventions. The care plan failed to document the resident had a full leg immobilizer (a brace to keep the leg straight and immobile). The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED]. The physician's orders [REDACTED].) as needed when resident removed the dressing. (The order was obtained after this surveyor asked to see the order.) The physician's orders [REDACTED]. The order directed staff to cover the wound bed with 4 x 4's, silver alginate (a dressing that absorbs exudates and forms a gel-like covering over the wound), cover with ABD pad and roll gauze, then cover with an ACE bandage. The Nurse's Note, dated 07/20/20 at 02:48 PM, documented the facility readmitted the resident to skilled care after she had a BKA of the left leg. The note further documented the resident had a full leg immobilizer and an ACE wrap over her wound that was to remain in place until her 07/23/20 physician appointment. The Nurse's Note, dated 07/24/20 at 06:40 PM, documented the resident pushed the leg immobilizer and dressing off four times during dayshift. The note further documented staff applied loose fitting tubi grip (elasticized bandage intended to aid recovery of an injured limb) over the wound and reapplied the leg immobilizer. The note documented the physician ordered a decrease in the resident's [MEDICATION NAME] (narcotic pain medication) to one tablet every eight hours as needed. The Nurse's Note, dated 07/29/20 at 08:40 PM, documented the resident removed the immobilizer and tried to remove the dressing. The note further documented staff readjusted the dressing, applied the immobilizer, and explained to the resident the immobilizer would keep the dressing and wrap into place. The resident denied removing the immobilizer. The Nurse's Note, dated 07/30/20 at 12:01 PM, documented the resident pulled off the immobilizer and the dressing from her left leg stump. The note further documented staff covered the wound with Abdominal (ABD) gauze pad (absorbs drainage from wounds), 4 x 4 gauze, secured the dressing with kling wrap, and reapplied the immobilizer. Staff asked the resident to leave the immobilizer and dressing on. The Nurse's Note, dated 07/31/20 at 09:00 PM, documented the resident removed the ace wrap to her dressing twice since 08:00 PM, and when staff checked on the resident, the dressing was completely off. The resident stated she did not remove the dressing. The Nurse's Note, dated 08/02/20 at 12:30 AM, documented staff reapplied the dressing of three ABD pads, 4 x 4 gauze and covered it with kling gauze, tape, and wrapped with an ACE wrap. The Nurse's Note, dated 08/02/20 at 05:41 PM, documented staff contacted the emergency room (ER) regarding the resident's pain and behaviors. The resident continued to cry out and removed the dressing off of her left leg wound. The note further documented the physician increased the resident's [MEDICATION NAME] to 20 mcg/hr every week, place an additional 10 mcg/hr patch that day and directed staff replace both

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F 0740 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) patches on 08/07/20. The Nurse's Note, dated 08/03/20 at 12:45 AM, documented the resident removed her wound dressing and staff reapplied the dressing. On 08/03/20 at 03:43 PM, observation revealed the resident in her recliner, footrest in the up position, the resident's dressing loose and appeared the resident had pulled on the gauze wrap. Further observation revealed the resident did not have the leg immobilizer on her left leg. On 08/04/20 at 01:13 PM, observation revealed the resident in her recliner, footrest in the up position, left leg immobilizer in place. On 08/05/20 at 01:28 PM, observation revealed the resident in her recliner, no dressing to her left leg wound and a 4 x 4 with dried blood still stuck to the wound. On 08/05/20 01:45 PM, observation revealed Licensed Nurse (LN) H placed a bed pad under the resident left leg stump, cleansed the wound with wound cleanser, applied a 4 x 4 and ABD pad, wrapped the dressing with an ACE wrap, and applied the immobilizer to the resident's left leg. On 08/04/20 at 10:45 AM, LN G stated the resident frequently removed the dressing and staff had to redress the wound. LN G verified there was not an order from the physician to redress the wound. On 08/04/20 at 1:31 PM, Certified Nurse Aide (CNA) P stated the resident frequently removed the bandage on the wound and did not like when staff put the immobilizer on. On 08/04/20 at 03:00 PM, CNA Q stated the staff try to check on the resident more often and when the resident removed the bandage they told the nurse so the wound could be redressed. On 08/05/20 at 01:34 PM, LN H stated the resident removed the bandage multiple times a day and would say she didn't take it off. LN H further stated she did not know what else they could try to keep the bandage on. On 08/06/20 at 11:37 AM, Administrative Nurse D stated she felt it was more of a behavior when the resident removed the dressing. Administrative Nurse D further stated the facility had tried the immobilizer with the ACE wrap, placing the resident's pant leg over the dressing, [MEDICATION NAME] over the wound, and the resident still removed the dressing. Administrative Nurse D stated the resident tells staff she does not take off the dressing and verified there were not interventions documented. Administrative Nurse D further stated the facility did not have a physician order [REDACTED]. The facility's Behavior Assessment and Monitoring policy, dated January 2020, documented problematic behavior would be identified and managed appropriately. The staff would document either in progress notes, behavior assessment forms, or other comparable approaches the following information about specific problem behaviors, the number and frequency of episodes, preceding or precipitating factors, interventions attempted, psychoactive drug monitoring, and the outcome associated with the interventions. The facility failed to appropriately manage R7's behavior of frequently removing the left leg wound dressings, placing the resident at risk for wound infection.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 44 residents. The sample included 12 residents. Based on observation and interview, the facility failed to maintain medication storage in a safe manner for one of two medication carts. Findings included: - On 08/03/20 at 11:17 AM, during initial tour, one medication cart found unlocked, and unattended by staff, at the north nurses station area. The cart contained medication cards, bottles, various dispensing containers from a pharmacy, and stock medications. The cart also contained over the counter and prescription medications, not limited to: [MEDICATION NAME], used to treat minor aches and pains, and reduce fever multivitamins, used as a dietary supplement magnesium oxide, used for magnesium deficiency stool softeners aspirin, used to treat pain, fever, headache, and inflammation iron, used to treat red blood cells that enable them to carry oxygen folic acid, a vitamin used to treat certain type of [MEDICAL CONDITION] (condition without enough healthy red blood cells to carry adequate oxygen to body tissues) [MEDICATION NAME], used as a laxative (used to help increase stool motility, bulk and frequency) [MEDICATION NAME], treats heartburn, a damaged esophagus, stomach ulcers and gastroespohageal reflux disease (back flow of stomach contents to the esophagus) [MEDICATION NAME], used to treat fever and mild to severe pain [MEDICATION NAME], used as laxative [MEDICATION NAME], used to treat fever and pain milk of magnesium, used as a laxative [MEDICATION NAME], used to treat pain and itching [MEDICATION NAME], used for [MEDICAL CONDITION] (inability to sleep) alendronate-used to treat and prevent [MEDICAL CONDITION] (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) [MEDICATION NAME], to treat diarrhea (loose, watery stools that occur more frequently than usual) [MEDICATION NAME], to treat pain, itching, and swelling by many skin diseases [MEDICATION NAME], to treat swelling caused by heat, liver and kidney disease apexiban, to prevent blood clots [MEDICATION NAME], used to treat depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), [MEDICAL CONDITION] (anxiety disorder characterized by recurrent and persistent thoughts, ideas and feelings of obsessions severe to cause marked distress, consume considerable time or significantly interfere with the resident's occupational, social or interpersonal functioning) and posttraumatic stress disorder (psychiatric disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress, such as natural disaster, military combat, serious automobile accident, airplane crash or physical torture), and panic attacks [MEDICATION NAME] inhaler, used to prevent and treat difficulty breathing [MEDICATION NAME] inhaler, used to treat [MEDICAL CONDITION] various eye drops On 08/03/20 at 11:17 am, Licensed Nurse (LN) H, verified the cart should have been locked. On 08/06/2020 at 01:38 PM, Administrative Nurse D verified the medication cart should be locked if unattended. The facility's Storage of Medication policy, dated January 2020, documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals shall be locked when not in use, and trays or cart to transport such items shall not be left unattended if open or otherwise potentially available to others. The facility failed to maintain and secure medications in a safe manner, placing eight cognitively impaired, independently mobile residents at risk for medication accessibility and ingestion.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, and serve food under sanitary conditions in accordance with professional standards for the 44 residents who resided in the facility and received meals from the facility kitchen. Findings included: - On [DATE] at 10:30 AM, observation during initial tour of the facility revealed the nutrition snack room refrigerator contained the following unlabeled and undated/or expired items: four undated sandwiches one undated rice cereal treat one undated four-ounce (oz) container of pineapple one undated four oz container of cottage cheese one undated 10 oz container of grape tomatoes one six oz container of vanilla low-fat yogurt with snicker crunch with expiration date of [DATE] one package of undated grapes one undated bag of four slices of watermelon one container of undated green and red Jello On [DATE] at 10:40 AM, Certified Nurse Aide (CNA) M verified the items in the refrigerator needed to be dated. Dietary Staff (DS) BB stated the cook's responsibility to ensure no expired or unlabeled food in the nourishment refrigerator. On [DATE] at 11:45 AM, observation during tour of the kitchen revealed an unidentified staff purse lying on the countertop of the sink area where resident beverages were prepared. Observation further revealed DS CC's purse lying on the countertop where bananas were stored. On [DATE] at 11:29 AM, DS BB verified staff should not store their purses in the kitchen prep area and the facility had a designated area for employee's personal items. The facility's Food Safety Requirement policy, dated February 2020, documented the facility will comply with safe food handling practices. All foods stored in the refrigerator will be covered, labeled, and dated (used by date). The facility failed to prepare, store, and serve food under sanitary conditions for the 44 residents who resided in the facility and received meals from the facility kitchen, placing the residents 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.** The facility had a census of 44 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to follow droplet isolation precautions to prevent the development and transmission of communicable diseases and infection for two isolation rooms on two of four halls. Findings included: On 08/04/20 at 01:45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SMITH CENTER HEALTH AND REHAB	**117 W 1ST STREET #369 SMITH CENTER, KS 66967**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) PM, observation revealed Social Service Staff (SSS) X in droplet isolation room on South Hall with gown not closed in back and exited room rolling up gown into hallway. SSS X then stopped in hallway and asked the housekeeper who took the trash can out of the resident's room. Further observation revealed the housekeeper provided a trash bag, and SSS X placed the soiled gown into the bag. SSS X walked down the hall to the front entrance and placed the bag in the biohazard room. On 08/04/20 at 02:30 PM, observation revealed the nurse stood outside the doorway of the isolation room in South Hall with droplet sign on door talking to staff with the back of the gown open and loose around the neck in front. On 08/04/20 at 03:12 PM, observation revealed Isolation room with droplet sign on East Hall and door wide open. Further observation revealed Activity Staff (AS) Z in room with isolation gown over her arms up to shoulders, back of gown open, face shield and mask, and no gloves. AS Z sat on resident's bed writing on an orange envelope on resident's bedside table. On 08/06/20 at 08:38 AM, observation revealed isolation room with droplet sign on South Hall, door open, and resident ate breakfast seated in chair in room. On 08/04/20 at 04:20 PM, SSS X verified she left a droplet isolation room with her soiled gown, placed it into a bag while in the hallway, and walked down the hall to the front entrance to place the bag in the biohazard room. On 08/06/20 at 08:40 AM Administrative Nurse (AN) D stated prior to entering isolation rooms staff were required to sanitize hands, put on their gowns, gloves, masks and could wear face shield if they were coughing prior to entering room. AN D stated prior to exiting isolation rooms staff should remove gowns, gloves and masks inside of room and discard in room. AN D verified the doors of isolation rooms should remain closed and gowns should cover staff's clothing. On 08/06/20 at 11:29 AM, Licensed Nurse (LN) I verified resident's in isolation precautions for droplet should have their door closed, the gowns should cover the staff's body and be closed in the back. LN I verified staff had not followed correct procedure and training needed to be completed. The facility's Isolation-Categories of Transmission-Based precautions Policy, dated January 2020, stated Transmission-Based Precautions should be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. Droplet Precautions should be used for anyone who is documented or suspected to be infected with microorganisms transmitted by droplets (larger than five microns) (a micron is a unit of length equal to one millionth of a meter) that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning. The room door should be closed, the resident kept in the room, staff must wear approved respiratory protection when entering the room, staff should wear a gown (clean, nonsterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. The gown must be removed and hand hygiene performed before leaving the resident's environment. After removing the gown, the staff should not allow clothing to contact potentially contaminated environmental surfaces. The facility failed to follow droplet isolation precautions to prevent the development and transmission of communicable diseases and infection for two isolation rooms on two of four halls, placing residents and staff at risk of development and transmission of communicable diseases and infection.