

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E577	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2016
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NAME OF PROVIDER OR SUPPLIER ANDERSON COUNTY HOSPITAL LTCU	STREET ADDRESS, CITY, STATE, ZIP CODE 421 S MAPLE STREET PO BOX 309 GARNETT, KS 66032
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F 000 F 371 SS=F	<p>INITIAL COMMENTS</p> <p>The following citations represent the findings of a Health Resurvey,</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 32 residents. Based on observation, record review, and interview, the facility failed to store, prepare and serve food under sanitary conditions for the residents of the facility.</p> <p>Findings included:</p> <p>- On 3/9/16 at 2:05 PM, in the dining room, volunteer staff I and volunteer staff J were setting up supplies to wrap silverware. Volunteer staff J had washed his/her hands and put on gloves. Volunteer staff I had not washed his/her hands or put on gloves when he/she started picking up the silverware and transferring it to a table, touching the ends of the silverware which is used for eating. Volunteer staff I repeated picking up the silverware three times in this manner, and then proceeded to put on his/her gloves, without washing his/her hands. Volunteer staff I and J proceeded to wrap the silverware in a paper napkin and secure the napkin with a paper wrap.</p>	F 000 F 371		
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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 371	<p>Continued From page 1</p> <p>Volunteer staff J stated he/she and volunteer I wrap the silverware three times a week, and did not receive any training for wrapping of the silverware.</p> <p>On 3/9/16 at 8:30 AM, administrative nursing staff A stated he/she believed all volunteers who wrapped silverware received training on the proper way to handle the silverware.</p> <p>On 3/15/16 at 8:55 AM, dietary staff K stated the staff educated volunteers on the proper way to handle the silverware. The volunteers are to wash his/her hands, and to wear gloves, and then roll the silverware.</p> <p>On 3/15/16 at 9:29 AM, administrative laboratory staff G stated facility staff provide training to the volunteers just like they are employees.</p> <p>The facility policy, dated 11/24/14, for hand hygiene advised the guideline to prevent the dissemination of disease through the contact means of transmission. Hand hygiene was the single most important means of preventing the spread of disease. All employees will comply with the hand hygiene guidelines of the Centers for Disease Control and Prevention and procedures set forth in this policy. All employees will perform hand hygiene with either soap and water or an alcohol-based hand rub for routine decontaminating of hand. Routine indications for hand hygiene include: before eating, and before handling food.</p> <p>The facility failed to handle the silverware in a sanitary manner for the residents of the facility.</p> <p>- Observation, on 3/14/16 at 12:10 PM, revealed</p>	F 371			

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F 371	Continued From page 2 in the kitchenette, the individual compartments in the steam table with a build-up of a dark brown substance. Dietary staff C stated he/she thought housekeeping was to clean the steam table. On 3/15/16 at 8:36 AM, dietary staff K stated the cleaning of the steam table had not been put on the cleaning list when the dietary department moved from the old facility to the new facility. The housekeeping department cleans in the kitchenette. The undated facility policy for Operating and Cleaning instructions for the Aerohot Steam Table for daily cleaning advised staff to turn the control knob to the off position and allow the unit to cool before cleaning. Drain or remove the water from the well. Use a soft cloth or sponge with a mild detergent to clean the entire warmer assembly. Rinse completely with warm water and then dry. A plastic scouring pad and a mild detergent may be used to remove hardened food. The facility failed to store and handle foods under sanitary conditions for the residents of the facility.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	<p>Continued From page 3</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 32 residents. Based on observation, interview and record review, the facility failed to maintain an infection control program to prevent, recognize and control, to the extent possible, the onset and spread of infection within the facility through failure to track and trend infections and antibiotic use. In addition, the facility failed to ensure the containment of soiled linen and trash in a proper receptacle. Furthermore, the facility failed to ensure staff utilized the correct method for processing of laundry contaminated with c-difficile (a highly contagious bacteria spread by contact with feces).</p>	F 441			

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F 441	Continued From page 4 Findings included: - Observation, on 3-9-16 at 9:00 am, revealed a plastic bag, containing soiled clothing protectors collected from the residents and a plastic bag containing trash were placed directly on the floor near a housekeeping cart near the dining room. Observation, on 3-9-16 at 2:16 pm, revealed resident (#7's) nebulizer equipment positioned directly on the floor beside his/her bed. Observation, on 3-10-16, at 8:50 am, revealed a plastic bag, containing soiled clothing protectors collected from the residents and a plastic bag containing trash positioned directly on the floor near a housekeeping cart near the dining room. Observation, on 3-14-16 at 8:58 am revealed a plastic bag, containing soiled clothing protectors collected from the residents and a plastic bag containing trash positioned directly on the floor near a housekeeping cart near the dining room. Interview, on 3-14-16 at 8:58 am, with housekeeping staff L, revealed the bag of bibs and trash bag will be taken to the soiled utility room and placed in the laundry and trash barrels. Observation, on 3-14-16 at 9:52 am, revealed direct care staff D, placed a soiled bed saver and trash items directly on the floor and provided care to the resident. Staff D stated he/she should place the items in a bag. Observation, on 3-14-16 at 2:00 pm, revealed a plastic bag containing soiled mop heads, on the floor outside the laundry room. Laundry staff E dragged the bag into the soiled laundry area and	F 441			

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F 441	<p>Continued From page 5</p> <p>leakage from the bag was noted on the floor in the hallway and into the soiled laundry room.</p> <p>Interview, on 3-15-16 at 11:30 am, with administrative nursing staff A, revealed the soiled clothing protectors and trash were contained within a plastic bag and he/she did not believe this represented an infection control issue. Staff A stated there was not a policy directing staff not to place soiled items/resident care items directly on the floor.</p> <p>The facility failed to ensure the staff infection control practices were conducted in a manner to prevent the spread of infection amongst these residents at risk for infections.</p> <p>- Interview, on 3-14-16 at 2:00 pm, with laundry staff E, revealed the facility processed laundry from residents in isolation precautions for c-difficile, in the small high efficiency washing machine, and added 1/4 cup of bleach in the dispenser. Staff E stated he/she followed the facility policy for soiled isolation linen. Staff E stated staff were to record the water temperature for the machine daily.</p> <p>Interview. at 3-14-16 at 2:30 pm with maintenance staff H, revealed the water temperature was monitored by the gauge on the water line, and from the hot water tank, which was set at 170. Staff H stated he/she accessed the small high efficiency washing machine manufacturer on the Internet site to determine how many gallons of water were used per cycle, and figured the bleach dilution was 133 parts per million with 1/4 cup of bleach, however could not confirm if the bleach ratio was figured on the total load water volume verses just the wash cycle.</p>	F 441			

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F 441	<p>Continued From page 6</p> <p>The facility policy for isolation soiled linen processing, dated effective date 5/22/30 (year undetermined), supercedes 8/16/1999, advised staff to wash this laundry in the small washer with 1/4 cup of bleach, which was the policy laundry staff E confirmed he/she followed. The facility also had the same policy, dated 5/22/30 supercedes 8/16/99, with 1/2 cup of bleach indicated. Furthermore, a directive from the hospitality service manager, received as an email, dated 3-15-16, indicated facility staff should use "per CDC (center for disease control), 160 degree water with 50-150 pmm(parts per million) of bleach". Staff advised that in the small 18 lb (pound) washer to use "6 ounces of bleach (1/2 cup) per load".</p> <p>The facility failed to ensure the facility policy and procedure consistently directed staff on the appropriate method to process soiled isolation (for c-difficile) laundry, and in accordance established policy and procedures, to prevent the spread of infection.</p> <p>- Review of the culture result log, from March 2015 through January 2016, revealed positive culture results (those with organisms identified) were recorded with antibiotic used.</p> <p>Interview, on 3-15-16 at 9:29 am, with administrative laboratory staff G, revealed tracking of antibiotic use was done on culture results that had identified organisms for the long term care unit. Staff G confirmed lack of tracking of antibiotic's use even though the cultures were without organism growth, those done by an outside source, or antibiotics prescribed without cultures obtained.</p>	F 441		

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F 441	Continued From page 7 Interview, on 3-15-16 at 11:30 am with administrative nursing staff A, revealed a lack of tracking and trending of antibiotic use for the resident's of the long term care unit, other than verbal discussion with staff to identify residents with potential for c-difficile development. The facility failed to track and trend antibiotic use to prevent, recognize and control to the extent possible, the onset and spread of infections within the facility.	F 441		