

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

PRINTED: 03/31/2016  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>17E630</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  | (X3) DATE SURVEY COMPLETED<br><br><b>03/31/2016</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANTHONY COMMUNITY CARE CENTER</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>212 N 5TH AVE<br/>ANTHONY, KS 67003</b>                             |   |
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| F 000  | INITIAL COMMENTS  | F 000   |   |   |
| F 280<br>SS=E  | <p>The following citations represent Health Resurvey 69B611</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>The facility census totaled 27 residents with 15 included in the sample. Based on observation, interview and record review the facility failed to revise 4 of 15 residents' care plans when the residents' status changed regarding accidents (#14, #31), dental care (#17) and pressure ulcers (#15).</p> | F 280   |   |   |

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 280  | <p>Continued From page 1</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Review of resident #14's signed physician orders dated 2/3/16 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), CVA (the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain ), diabetes type 2 (when the body cannot use glucose, there's not enough insulin made or the body cannot respond to the insulin), hypothyroidism (condition characterized by decreased activity of the thyroid gland), hypertension (elevated blood pressure), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).</li> </ul> <p>Review of the significant change in status MDS dated 8/1/15 revealed the resident had severely impaired cognition. The resident had severely impaired decision making ability. The resident required extensive assistance of two with bed mobility, dressing, toileting and personal hygiene. The resident required extensive assist of one staff with transferring. The resident was non-ambulatory and was totally dependent on one staff for locomotion on and off the unit, dressing and bathing. The resident was always incontinent of bladder and bowel. The resident had 2 or more falls since the last MDS.</p> <p>Review of the quarterly MDS (minimum data set) dated 2/1/16 revealed the resident was unable to complete a BIMS (brief interview for mental status) due to cognitive impairment. The staff assessment for mental status revealed the resident 's long term and short term memory was severely impaired and had severely impaired</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 2</p> <p>decision making ability. The resident required extensive assistance of one staff for bed mobility, toileting, personal hygiene and minimal assistance with transfers and dressing. The resident was independent with ambulation in room and corridor. The resident was on a toileting program and frequently incontinent. The resident had 2 or more falls without injury since the last MDS. Medications included insulin injections, antipsychotic and diuretic medications.</p> <p>Review of the CAA (care area assessment) dated 8/1/15 revealed the following:<br/>Falls CAA- Resident has had several falls recently with increased weakness and unsteady gait. He/she required assistance with ambulation using a walker and with transfers.</p> <p>Review of the care plan with a date of 1/26/16 revealed the resident was a moderate risk for falls related to the need for a walker when ambulating. The resident had falls in the past, prior to arrival at this facility. Approaches included;<br/>Anticipate and meet needs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: exercise class or outings.</p> <p>Updates added to the care plan included falls on the following dates:<br/>7/12/16-The resident had a non injury fall with update to the care plan dated 7/12<br/>07/18/15 (6 days after the fall) included the resident would be toileted according to a toileting plan. No toileting plan found on the care plan. An intervention dated 7/23/16 revealed the staff educated the resident to use call light prior to</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 3</p> <p>getting up so that staff may help him/her.</p> <p>9/25/15- The resident had an actual fall. An update added to the care plan on 11/2/15 (over 30 days following the fall) included; Staff would continue interventions as listed on the at-risk fall care plan.</p> <p>11/1/15- The resident fell in his/her room. An intervention dated 11/22/15 (21 days after fall) included; Staff to continue fall precautions in place at the time.</p> <p>11/6/15-The resident had a fall with the intervention of reminding the resident not to reach for items out of his/her reach. The approach was ineffective due to the resident having severe cognitive impairment.</p> <p>1/6/16- The resident fell in his/her room with an intervention dated 1/7/16 of reminding the resident to ask for help getting up with a walker. The intervention was not an effective approach due to the resident's cognitive status.</p> <p>2/12/16-The resident had 2 falls on this day. Interventions included staff instructed to ambulate with the resident putting a hand over the resident's right hand to keep it on the walker.</p> <p>3/15/16- The resident fell in his room with no interventions added to the care plan.</p> <p>Review of the fall investigation dated 2/12/16 revealed the resident sat on the floor in the hall in front of the treatment cart. The resident stated his/her right hand would not stay on the walker. Staff assisted the resident off the floor. Hospice and DPOA notified. The resident had severe cognitive impairment.</p> <p>Review of the fall investigation dated 2/12/16 revealed the resident had a fall while getting out of his/her closet to go home and fell on his/her buttocks. The investigation form had an area for care plan revisions though the box for no revision</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 4 to the care plan marked on the form.</p> <p>Review of the fall investigation dated 2/22/16 revealed the resident sat in the dining room and attempted to get up and fell, grabbed for a chair and the chair fell on top of the resident. No injuries. No fall for that date documented on the care plan.</p> <p>Review of the fall investigation dated 3/6/16 revealed the resident was starting to pack to go home and fell in front of the closet with walker beside him/her and a pile of clothes on the floor. The investigation form lacked documentation of any new interventions to the care plan.</p> <p>Review of the fall investigation dated 3/15/16 revealed the resident sat on the floor in front of his/her recliner in the room with his/her walker in the closet. The resident had an armful of clothes. Resident reported he/she fell on his/her knees but could not get up so he/she turned to sit on his/her buttocks. Bruising noted to left upper arm and left elbow. The investigation form lacked documentation of any new interventions to the care plan.</p> <p>Review of a physician order form dated 2/23/16 revealed an order for OT (occupational therapy) to consult 1 time only for eating and ambulation and 1 time education to staff due to right sided weakness.</p> <p>Observation on 3/23/16 at 9:22 a.m. revealed the resident ambulating in the hall with the hairdresser using a walker. The resident had a slow shaky gait.</p> <p>Observation on 3/23/16 at 2:10 p.m. revealed the</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 5</p> <p>resident walking in the halls with his/her walker. The resident had house shoes with soles on his/her feet. The resident was very anxious and looking for something. The resident was approached by direct care staff G and directed to the afternoon activity but would not stay and continued to ambulate in the halls by him/herself.</p> <p>During an interview on 3/23/16 at 10:30 a.m. direct care staff G reported the resident was often anxious and staff would attempt to redirect him/her to an activity or to his/her room and turn the TV on. He/she required assistance with him/her daily care. Staff G was not aware of any toileting program for the resident. They just offered the resident the bathroom before and after meals and if the resident was trying to get out a door that meant the resident needed to use the bathroom.</p> <p>During an interview on 3/23/16 at 4:15 p.m. direct care staff D reported the resident at times needed assistance with transfers. The resident had a fall alarm (a pad that connected to an alarm that sounds when the resident attempts to get out of bed) on his/her bed and fall mat (padded mat) by his/her bed. When the resident was walking around, he/she tried to distract the resident and involve him/her in activities. Staff D reported staff supervised the resident but did not do 1:1 with the resident when he/she was anxious. If the resident was anxious, he/she reported that to the nurse for the resident's safety. Staff D was unaware of a planned toileting plan, just the usual before and after meal and when the resident got up and went to bed.</p> <p>During an interview on 03/28/2016 at 10:42:a.m. licensed nurse F reported the resident used the</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 6</p> <p>bathroom frequently before and in between meals. Nurse F did not know of any formal toileting program reporting staff just asked him/her if he/she needed the bathroom when he/she would go to the outside doors with that being a clue to the staff to take him/her to the bathroom. The resident had a fall mat, a bed alarm and had another chair in his/her room removed. Nurse F reported the nurse on duty was responsible to update the care plan. The changes went on the dashboard (opening page on the computer program used for all medical records and charting accessed by all staff). to relay changes to other staff. Nurse F reported the director of nurses did the fall investigation.</p> <p>During an interview on 3/24/16 at 3:10 p.m. administrative nurse A stated, he/she was behind with the fall investigations and could not locate a fall investigation for 11/24/15, 1/10/16 and 1/30/16. The nurse stated he/she had not got to do an investigation for the fall on 3/15/16. Nurse A confirmed there was no formal toileting plan for the resident.</p> <p>The facility failed to develop and implement appropriate interventions after each fall to prevent the resident from having further falls.</p> <p>- Review of resident #17's signed physician orders dated 1/7/16 revealed the following diagnoses: multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord) and generalized muscle weakness.</p> <p>Review of the quarterly MDS (minimum data set) dated 2/24/16 revealed a BIMS (brief interview for mental status) score of 15 indicating cognition intact. The MDS indicated the resident required</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 7</p> <p>limited assistance for personal hygiene. The resident had no dental problems marked.</p> <p>The annual MDS dated 11/24/15 identified the same cognitive status and assistance with ADLs and again no dental problems were marked.</p> <p>Review of the CAA (care area assessment) dated 12/7/15 revealed the following: Cognition CAA, the resident is alert and oriented with the potential for decline in cognitive status. The ADL CAA indicated the resident needed assistance with many of his/her ADLs due to inability to transfer. The Dental CAA did not trigger for a further review.</p> <p>Review of the care plan with a date of 12/2/15 revealed the care plan directed staff that the resident required no assistance with mouth care. Under the nutrition care plan the problem noted that the resident had bad teeth and recently had the last two teeth pulled. A separate problem listed the resident as edentulous, denied problems with gums or mouth and directed staff to inspect the oral cavity quarterly.</p> <p>On 12/7/15 an outside dental service made a clinical note of patient uncooperative for exam, would not come to the exam room. The facility reported the resident was seen at the most recent visit by the outside dental service, however the dental service had not yet supplied the facility with notes of the visit.</p> <p>Observation on 3/23/16 at 1:10 pm revealed the resident just now placed and received his/her order for lunch. The resident ate a sausage and egg sandwich without difficulties.</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 8</p> <p>Observation on 3/28/16 at 9:49 am with nurse F revealed the resident had almost full lower natural teeth, no teeth on top but in the front was a fragmented piece still within the gum.</p> <p>On 3/23/16 at 2:40 pm the resident reported he/she did not have any teeth on the top, still has teeth on the bottom which he/she brushed. The resident said he/she had the teeth pulled because they were bad, breaking and got infected.</p> <p>Interview on 3/23/16 at 3:50 pm with direct care staff L revealed no knowledge of any chewing or dental problems.</p> <p>On 3/24/16 at 10:43 am direct care staff G said he/she was not sure about the resident ' s dental status because the resident does his/her own oral care. Staff G said the resident had not reported any problems and did see the dental services provided services at the facility.</p> <p>On 3/24/16 nurse F said that the hygienist did see the resident on the last visit, recommended dentures and planned to have the dentist talk with the resident at next visit.</p> <p>On 3/28/16 at 9:49 am nurse F confirmed the care plan indicated the resident had no teeth at all and he/she thought the resident still had 2 teeth. At this time observation of the resident ' s oral cavity revealed bottom teeth present and nurse F confirmed the care plan was not accurate and needed revision.</p> <p>On 3/28/16 at 10:00 am administrative nurse A confirmed the care plan dental status was inaccurate.</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 9</p> <p>The facility provided a policy titled, " Comprehensive Care Plan " with a revision date of 7/10/14. The policy directed staff that the care plan will be driven by the MDS and CAAs. The care plan will be developed by the interdisciplinary team to the extent practicable, the resident, and resident ' s family or legal representative. The resident ' s care plan will be reviewed at least every ninety (90) days and as needed. The care plan will also be reviewed if the resident is hospitalized, or experiences a significant change in physical or mental condition.</p> <p>The facility failed to use the results of the MDS and CAAs to accurately develop a comprehensive care plan to address the resident ' s dental status.</p> <p>- Review of resident #15's signed physician orders dated 2/2/16 revealed the following diagnoses: chronic ischemic heart disease (a decreased supply of oxygenated blood to the heart muscle), type 2 diabetes mellitus (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin), restless leg syndrome (a condition characterized by a nearly irresistible urge to move the legs, typically in the evenings), muscle spasms , and congestive heart failure (a condition when the heart output is low and the body becomes congested with fluid).</p> <p>Review of the quarterly MDS (minimum data set) dated 2/7/16 revealed a BIMS (brief interview for mental status) score of 15 indicating cognition intact. The MDS identified the resident as independent with all ADLs (activities of daily living), continent of bowel and bladder, The MDS identified the resident with an unhealed pressure</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 10</p> <p>ulcer(s) and coded as unstageable-Deep tissue: Suspected deep tissue injury in evolution that was not present at the time of admission/reentry.</p> <p>The annual MDS dated 11/7/15 included the same BIMS, independent with ADLs, continent of bowel and bladder, no pressure ulcers and not at risk.</p> <p>Review of the CAA (care area assessment) dated 11/21/15 revealed the following: it did not trigger for a further review of pressure ulcer care area. The ADL CAA included that the resident needed stand by assistance with shower.</p> <p>Review of the care plan with a date of 3/2/16 revealed: No care plan for pressure ulcer prevention or treatment of actual pressure ulcer. The care plan indicated the resident used a four wheeled walker for ambulation and a wheelchair for long distances. The care plan identified the resident as alert and oriented, used side rails to turn and reposition self, needed extra time for dressing and undressing due to tiredness and pain associated with medical diagnosis.</p> <p>On 1/3/16 at 9:57 am review of the skin/wound which identified the resident ' s inside left heel had a blister that measured 1.8cm (centimeters) by 1.6cm. The noted indicated the wound edges were clear and surrounding skin was dry, warm, pink and intact. The note indicated the resident reported having slight pain which was more when resident put his/her shoes on. The nurse helped the resident take off his/her shoe and the blister was noted. The nurse evaluated the resident's shoes as not being tight and that the resident ambulated very short distances. The nurse wrote the resident is not sure how the blister occurred.</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 11</p> <p>Weekly notes were made between 1/3/16 and 2/25/16 all identified the area as a blister. On 2/25/16 the skin/wound note did not include measurements and the Narrative included;<br/>"Resident states he/she monitors his/her skin and areas are improving. Blister on left heel skin sloughed off and resident denies pain/discomfort. " On 2/29/16 the left heel area was described as an old blister with measurements of 1.8cm by 2 cm.</p> <p>Review of the treatment record for January 2016, February 2016 and March 2016 revealed the treatment on the left heel began on 1/4/16 to monitor the area then on 1/9/16 changed to a dry dressing to the left heel blister at all times.</p> <p>On 3/23/16 at 9:00 am observation revealed the resident rested in bed with eyes closed on his/her left side with body pillows to both sides of upper body, head of bed elevated approximately 30 degrees.</p> <p>On 3/24/16 at 10:00 am observation with nurse F revealed the resident ' s bilateral lower legs were discolored/dark pigment from top of the feet to just below the knees with areas on the lateral aspects of the feet being purple in color. The resident had socks and shoes on which the nurse removed. The resident independently stood from the wheelchair, placed his/her right knee on the mattress and got into bed then rolled over to allow visualization of the left heel. Observation revealed no coverings other than the sock of an area on the left inner heel. The inner heel skin showed an area of darker pink about the size of a half dollar that was blanchable and had some dried sloughing skin around the edges.</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 12</p> <p>On 3/28/16 at 7:45 am administrative nurse A confirmed the resident ' s care plan lacked interventions following the development of the pressure ulcer or measures taken to prevent future development.</p> <p>The facility ' s policy titled, " Comprehensive Care Plans " , dated 7/10/2014 directed staff that the facility would develop a comprehensive care plan for each resident, the MDS and CAAs drive the care plan and the staff would review the care plan if the resident experienced a significant change in physical or mental condition.</p> <p>The facility failed to review/revise the care plan for this resident who developed a pressure ulcer and failed to develop interventions to prevent future pressure ulcer development for this resident.</p> <p>- Review of resident #31's Admission MDS (Minimum Data Set) dated 2/29/16 revealed a BIMS (Brief Interview for Mental Status) score of 14, indicating no cognitive impairment. The resident required limited assistance of one person with transfers, walking in the room and walking in the corridor. The resident was not steady, and could only stabilize with staff assistance with all aspects of balance during transitions and walking.</p> <p>Review of the resident's Activities of Daily Living (ADL) Functional Status CAA (Care Area Assessment) dated 2/22/16 revealed the resident had to have assistance with transfers, ambulation, and mobility. The resident ambulated with a walker and with assistance of one staff.</p> <p>Review of the Falls CAA dated 2/22/16 revealed</p> | F 280   |   |                      |   |

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| F 280  | <p>Continued From page 13</p> <p>the resident had a risk for falls due to unstable gait, the need for staff assistance, weakness, and imbalance.</p> <p>Review of the resident's care plan revealed the resident had a high risk for falls related to the need for assistance and weakness. The resident had some confusion and started to have some hallucinations (sensing things while awake that appear to be real, but the mind created). The resident had trouble sitting up unassisted and had to have assistance of one to transfer. The resident had weakness related to his/her terminal diagnosis of bladder cancer. Interventions included: Staff were to anticipate his/her needs. Ensure the resident had his/her call light where he/she could locate it (initiated on 3/13/16). Staff were to ensure the resident wore appropriate footwear or non-skid socks when ambulating or mobilizing in the wheelchair. Be aware the resident often tried to lean back when he/she stood which caused him/her to slide. Staff were to ensure the resident leaned forward when he/she stood up (initiated on 3/13/16). Use one person to assist the resident to transfer and ambulate the resident with a walker (initiated on 3/14/16). The care plan did not include dates of each fall incident and did not include interventions specific to those dates for 3/9/16, 3/10/16 and 3/11/16.</p> <p>During an interview on 3/28/16 at 2:00 PM licensed nursing staff F stated fall interventions should be included on the care plan.</p> <p>During an interview on 3/28/16 at 12:21 PM administrative nursing staff A acknowledged there were no interventions on two of the Post-Fall Assessments dated 3/10/16 and 3/11/16. Staff A stated it is the nurse on duty's responsibility to</p> | F 280   |   |                      |   |

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| F 280  | Continued From page 14<br>add interventions to the resident's care plan at the time of the fall. Staff A acknowledged staff did not update the care plan with interventions specific to each fall incident.<br><br>Review of the Accident and Incidents Policy revised on July 10, 2014 revealed fall interventions must be individualized to each resident for each occurrence.<br><br>The facility failed to update resident #31's care plan to include each fall incident as well as an intervention specific to each fall incident.  | F 280   |   |                      |   |
| F 314<br>SS=D  | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility census totaled 27 residents with 15 residents sampled. Based on observation, interview and record review the facility failed to investigate causal factors when a resident developed a pressure ulcer and failed to develop interventions to prevent further pressure ulcers for 1 of 1 sampled residents. (#15)<br><br>Findings included: | F 314   |   |                      |   |

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| F 314  | <p>Continued From page 15</p> <p>- Review of resident #15's signed physician orders dated 2/2/16 revealed the following diagnoses: type 2 diabetes mellitus (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin), low back pain, restless leg syndrome (a condition characterized by a nearly irresistible urge to move the legs, typically in the evenings), and muscle spasms.</p> <p>The annual MDS (minimum data set) dated 11/7/15 revealed a BIMS (brief interview for mental status) score of 15, indicating intact cognition. The resident was independent with all activities of daily living (ADLs), continent of bowel and bladder, the resident measured 60 inches tall and weighed 200 pounds with noted weight gain. The resident had no pressure ulcers and was not identified as at risk for pressure ulcers.</p> <p>Review of the quarterly MDS dated 2/7/16 revealed no change in cognition, ADL abilities, bowel and bladder incontinence, or height. The resident weighed 219 pounds with no significant weight loss noted. The resident had a pressure reducing device for the bed.</p> <p>Review of the Pressure Ulcer CAA (care area assessment) from the 11/7/15 MDS did not trigger for further assessment.</p> <p>Review of the ADL CAA dated 11/21/15 revealed the resident needed stand by assistance with a shower. This CAA did not include anything about pressure ulcers or risk for pressure ulcer.</p> <p>Review of the care plan with a date of 3/2/16 revealed nothing in the care plan related to</p> | F 314   |   |                      |   |

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| F 314  | <p>Continued From page 16</p> <p>prevention or treatment of pressure ulcers. The care plan indicated the resident used a four wheeled walker for ambulation and a wheelchair for long distances, the resident was alert and oriented, and used side rails to turn and reposition him/herself.</p> <p>Review of the progress notes revealed an entry on 12/31/15 at 10:34 am, which revealed the resident refused to let the nurse assess his/her skin. Scabs were still present on his/her right ear and the resident applied cream in his/her room. The resident ' s arms had multiple bruises from elbows to forearms, back of his/her hands and fingers. The resident reported the rest of his/her skin " is fine " .</p> <p>On 1/3/16 at 9:57 am a progress note identified the resident ' s inside left heel had a blister measuring 1.8 cm (centimeters) by 1.6 cm. The note indicated the wound edges were clear and surrounding skin as dry, warm, pink and intact. The resident reported having slight pain which increased when the resident put his/her shoes on. The nurse helped the resident take off his/her shoe and the nurse noted the blister on the left heel. The nurse evaluated the resident's shoes and determined the shoes were not tight. The note indicated the resident ambulated short distances. The nurse wrote the resident did not know how the blister occurred.</p> <p>Weekly notes were made between 1/3/16 and 2/25/16 and all identified the area to the heel as a blister.</p> <p>On 2/25/16 the skin/wound note did not include measurements and the narrative included the resident stated he/she monitored his/her skin and</p> | F 314   |   |                      |   |

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| F 314  | <p>Continued From page 17</p> <p>areas were improving. The blister on left heel skin sloughed off (separated from surrounding living tissue) and the resident denied pain/discomfort.</p> <p>On 2/29/16 in the skin/wound note, staff described the area as an old blister with measurements of 1.8 cm by 2 cm.</p> <p>Though neither of the notes on 2/25/16 or 2/29/16 noted the blister as healed, there were no further notes about the area through 3/24/16.</p> <p>Review of the treatment record for January 2016, February 2016 and March 2016 revealed the treatment on the left heel began on 1/4/16 to monitor the area then on 1/9/16, staff added a dry dressing to the left heel blister at all times until discontinued on 3/10/16.</p> <p>On 3/23/16 at 9:00 am, observation revealed the resident rested in bed with his/her eyes closed on his/her left side with body pillows to both sides of his/her upper body, with the head of the bed elevated approximately 30 degrees. At 9:15 am and 9:30 am the resident remained positioned the same. At 9:45 am observation revealed the resident wheeled him/her self out of the room and he/she had socks and shoes on.</p> <p>On 3/23/16 at 3:20 pm observation revealed the resident sat in his/her wheelchair outside smoking, appropriately dressed with socks and shoes on. At 3:40 pm, the resident remained outside. At 3:53 pm, the resident wheeled him/herself back into the building, to his/her room, parked the wheelchair, and stood up to walk over to his/her easy chair.</p> <p>On 3/24/16 at 10:00 am observation revealed</p> | F 314   |   |                      |   |

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| F 314  | <p>Continued From page 18</p> <p>both of the resident ' s lower legs were discolored/dark pigmented from the top of the feet to just below the knees with areas on the outer aspects of the feet which were purple in color. The resident had socks and shoes on, which the nurse removed. The resident independently stood from the wheelchair, placed his/her right knee on the mattress and got into bed then rolled over to allow visualization of the left heel. Observation revealed no coverings other than the sock of an area on the left inner heel. The inner heel skin showed an area of darker pink and blanchable (a temporary whitening of the skin when pressed, then turns pink when released, indicating blood flow return to the area) about the size of a half dollar that had some dried sloughing (shedding or removing of a dead area of skin) skin around the edges.</p> <p>At 3/24/16 at 10:00 am the resident reported at first he/she did not know what caused the blister but wondered if it happened because he/she wore TED hose (a compression stocking to aide with venous circulation) and it made his/ her shoes loose so his/her foot moved around in the shoe. The resident said it was not there when he/she went to bed but when got up next morning it hurt. The resident reported the mattress on the bed belonged to him/her. He/she stated the bed had a standard mattress (not a mattress with a pressure reducing surface). The resident also said he/she did not sleep with anything under his/her feet to keep them off the mattress. The resident reported the facility gave him/ her booties to wear but he/she kept kicking them off when he/she slept.</p> <p>On 3/23/16 at 3:50 pm direct care staff L did not know about any sore places on the resident and</p> | F 314   |   |                      |   |

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| F 314  | <p>Continued From page 19</p> <p>reported the nurses completed treatments. Staff L reported the resident was independent with ADLs and would call if he/she needed help for some reason. Staff L did not know the resident ' s pressure ulcer risk.</p> <p>On 3/24/16 at 10:25 am direct care staff G said he/she knew the resident had a sore but did not know the cause and reported it healed. Staff G reported the resident as independent with turning and repositioning. Staff G said the resident slept with lots of pillows but nothing under his/her feet.</p> <p>On 10/24/16 at 10:00 am licensed nurse F reported he/she had discovered the area on the resident ' s left heel and did not know the cause. Nurse F described the area as a blister. He/she reported he/she checked the resident ' s shoe and it did not seem too tight. Nurse F reported the area as a fluid filled blister that dried up and fell off.</p> <p>On 3/23/16 at 10:00 am administrative nurse A reported the resident ' s area on the left heel dried up, sloughed off and healed in the middle of February 2016. He/she reviewed the progress notes and reported the note dated 2/25/16 said the skin had sloughed off. Nurse A confirmed the note did not classify the area as healed. He/she confirmed staff were to complete skin/wound documentation in the weekly skin/wound note. Nurse A did not know the cause of the area on the resident ' s inner left heel and stated he/she did not conduct a root cause analysis. On 3/28/16 at 7:45 am administrative nurse A confirmed the resident ' s care plan lacked interventions following the development of the pressure ulcer regarding treatment of the ulcer and interventions to prevent further pressure ulcers.</p> | F 314   |   |                      |   |

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| F 314  | Continued From page 20<br><br>Review of the facility's policy titled Skin and Wound Assessment dated 7/10/14 revealed the following directions to staff: any skin issues brought to the charge nurses' attention would be promptly assessed and if needed the Director of Nursing or the designee would assess as well. The skin issue must be investigated. To investigate the skin issue, the nurse must assess the etiology (cause) of the skin issue. Once the etiology has been determined the cause must be sought, such as: trauma, pressure, shearing, friction from an object or other source, disease process, any other signs and symptoms of interest, recent lab draws, surgeries, new shoes, chair etc. Interventions would vary depending upon the etiology of the skin issue. The definition of a pressure ulcer included any lesion caused by unrelieved pressure that damaged underlying tissue.<br><br>The facility failed to investigate the development of a pressure ulcer to determine causal factors and develop interventions to prevent future pressure ulcer development for this resident. | F 314   |   |                      |   |
| F 323<br>SS=E  | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced  | F 323   |   |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                         |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>17E630</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>03/31/2016</b> |
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| F 323  | <p>Continued From page 21</p> <p>by:</p> <p>The facility had a census of 27 residents with 15 residents included in the sample. Based on interview, observation and record review the facility failed to develop and implement fall interventions after falls to prevent further falls for 2 of 3 residents reviewed for accidents. (#31 and #14)</p> <p>Findings included:</p> <p>Review of resident #31 ' s Admission MDS (Minimum Data Set) dated 2/29/16 revealed a BIMS (Brief Interview for Mental Status) score of 14, indicating the resident had no cognitive impairment. The resident required limited assistance of one person for transfers, walking in the room, and walking in the corridor. The resident was not steady, and could only stabilize with staff assistance with all aspects of balance during transitions and walking.</p> <p>Review of the resident ' s Activities of Daily Living (ADL) Functional Status CAA (Care Area Assessment) dated 2/22/16 revealed the resident had to have assistance with transfers, ambulation, and mobility. The resident ambulated with a walker and with assistance of one staff.</p> <p>Review of the Falls CAA dated 2/22/16 revealed the resident had a risk for falls due to unstable gait, the need for staff assistance, weakness, and imbalance.</p> <p>Review of the resident ' s care plan revealed the resident had a high risk for falls related to the need for assistance and weakness. The resident had some confusion and started to have some hallucinations (sensing things while awake that</p> | F 323   |   |                      |   |

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| F 323  | <p>Continued From page 22</p> <p>appear to be real, but the mind created). The resident had trouble sitting up unassisted and required assistance of one to transfer. The resident had weakness related to his/her terminal diagnosis of bladder cancer. Interventions included: Staff were to anticipate his/her needs. Ensure the resident had his/her call light where he/she could locate it (initiated on 3/13/16). Ensure the resident wore appropriate footwear or non-skid socks when ambulating or mobilizing in wheelchair. Be aware the resident often tried to lean back when he/she stood which caused him/her to slide. Ensure the resident leaned forward when he/she stood up (initiated on 3/13/16). Use one person to assist the resident to transfer and ambulate the resident with a walker (initiated on 3/14/16).</p> <p>Review of the Fall Risk Assessment dated 2/22/16 revealed the resident had no history of falls within the last six months. The resident had adequate ability to see in adequate light with glasses on. The resident did not have behaviors. The resident could not independently come to a standing position and used an assistance device.</p> <p>Review of the Interdisciplinary Post-Fall Assessment dated 3/10/16 revealed staff found the resident on the floor in his/her room. Staff found the resident lying on his/her back beside the bed with blankets under him/her. The resident stated he/she smelled gas and tried to leave the building. The resident had on non-skid socks. The resident experienced increased confusion and hallucinations. Staff failed to develop and implement new interventions to prevent further falls.</p> <p>Review of the Interdisciplinary Post-Fall</p> | F 323   |   |                      |   |

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| F 323  | <p>Continued From page 23</p> <p>Assessment dated 3/11/16 revealed staff found the resident crawling on the floor across his/her room. The resident stated no one would help him/her get to work. The report revealed the resident had experienced confusion and hallucinations. Staff determined the potential cause of the falls to be the resident experienced increased confusion, hallucinations, and the resident got up without assistance. Staff failed to develop and implement new interventions to prevent further falls.</p> <p>An observation on 3/24/16 at 2:39 PM revealed the resident lay in bed with his/her call light within reach and he/she had on socks. The resident moved around in bed a lot but did not transfer or get up out of bed.</p> <p>During an interview on 3/28/16 at 2:00 PM licensed nursing staff F confirmed the resident to be a fall risk. Staff F stated early on the resident used the call light. Staff F stated the resident used his/her call light frequently but had become more confused. Staff F stated the fall interventions should be included on the care plan.</p> <p>During an interview on 3/28/16 at 12:21 PM administrative nursing staff A acknowledged there were no interventions on two of the Post-Fall Assessments dated 3/10/16 and 3/11/16. Staff A stated it is the nurse on duty 's responsibility to add interventions to the resident 's care plan at the time of the fall. Staff A acknowledged staff did not update the care plan with interventions specific to each fall incident.</p> <p>Review of the Accident and Incidents Policy revised on July 10, 2014 revealed fall interventions must be individualized to each</p> | F 323   |   |                      |   |

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| F 323  | <p>Continued From page 24<br/>resident for each occurrence.</p> <p>The facility failed to implement fall interventions following each fall the resident experienced to prevent further falls.</p> <p>- Review of resident #14's signed physician orders dated 2/3/16 revealed the following diagnoses: dementia (progressive mental disorder characterized by failing memory, confusion), cerebrovascular accident (CVA- the sudden death of brain cells due to lack of oxygen when the blood flow to the brain is impaired by blockage or rupture of an artery to the brain), diabetes type 2 (when the body cannot use glucose, there is not enough insulin made or the body cannot respond to the insulin) and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain).</p> <p>Review of the significant change in status MDS (minimum data set) dated 8/1/15 revealed the resident had severely impaired cognition with severely impaired decision making abilities. The resident required extensive assistance of two staff with bed mobility, toileting and personal hygiene. The resident required extensive assist of one staff with transferring. The resident could not walk and totally dependent on one staff for locomotion on and off the unit. The resident always had incontinence of bladder and bowel. The resident fell 2 or more times since the last MDS.</p> <p>Review of the quarterly MDS dated 2/1/16 revealed the resident had short and long term memory problems and had severely impaired decision making ability. The resident required</p> | F 323   |   |                      |   |

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| F 323  | <p>Continued From page 25</p> <p>extensive assistance of one staff for bed mobility and toileting, and minimal assistance with transfers, and independent with ambulation in room and corridor. The resident had a toileting program and frequent incontinence. The resident had 2 or more falls without injury since the last MDS. Medications included insulin injections, antipsychotic and diuretic medications.</p> <p>Review of the Falls CAA (care area assessment) dated 8/1/15 revealed the resident had several falls recently with increased weakness and unsteady gait. He/she required assistance with ambulation using a walker and with transfers.</p> <p>Review of the care plan with a date of 1/26/16 revealed the resident had a moderate risk for falls related to the need for a walker when ambulating. The resident fell prior to arrival at the facility. Approaches included: Anticipate and meet the resident 's needs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as exercise class or outings.</p> <p>On these dates, staff updated the care plan for falls occurring on:</p> <p>7/12/16-The resident had a non injury fall with update to the care plan dated 7/12<br/>07/18/15 (6 days after the fall) included the resident would be toileted according to a toileting plan. No toileting plan found on the care plan. An intervention dated 7/23/16 revealed the staff educated the resident to use call light prior to getting up so that staff may help him/her.<br/>9/25/15- The resident had an actual fall. An update added to the care plan on 11/2/15 (over 30 days following the fall) included; Staff would</p> | F 323   |   |                      |   |

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| F 323  | <p>Continued From page 26</p> <p>continue interventions as listed on the at-risk fall care plan.</p> <p>11/1/15- The resident fell in his/her room. An intervention dated 11/22/15 (21 days after fall) included; Staff to continue fall precautions in place at the time.</p> <p>11/6/15-The resident had a fall with the intervention of reminding the resident not to reach for items out of his/her reach. The approach was ineffective due to the resident having severe cognitive impairment.</p> <p>1/6/16- The resident fell in his/her room with an intervention dated 1/7/16 of reminding the resident to ask for help getting up with a walker. The intervention was not an effective approach due to the resident's cognitive status.</p> <p>2/12/16-The resident had 2 falls on this day. Interventions included staff instructed to ambulate with the resident putting a hand over the resident's right hand to keep it on the walker.</p> <p>3/15/16- The resident fell in his room with no interventions added to the care plan.</p> <p>Review of the fall investigation dated 2/12/16 revealed the resident sat on the floor in hall in front of the treatment cart. The resident stated his/her right hand would not stay on the walker. Staff assisted the resident off the floor. The resident had severe cognitive impairment. On the fall investigation form, staff marked a box for care plan updates indicating no new interventions were placed on the care plan.</p> <p>Review of the fall investigation dated 2/12/16 revealed the resident had a fall while getting out of his/her closet to go home and fell on his/her buttocks. On the fall investigation form, staff marked a box for care plan updates indicating no new interventions were placed on the care plan.</p> | F 323   |   |                      |   |

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| F 323  | Continued From page 27<br><br>Review of the fall investigation dated 2/22/16 revealed the resident sat in the dining room and attempted to get up and fell, grabbed for a chair and the chair fell on top of the resident. The resident had no injuries. The care plan lacked documentation of a fall occurring on that date, or interventions put in place to prevent further accidents<br><br>Review of the fall investigation dated 3/6/16 revealed the resident started to pack to go home and fell in front of the closet with the walker beside him/her and a pile of clothes on the floor. The nurse documented no new interventions to be added to the care plan<br><br>Review of the fall investigation dated 3/15/16 revealed the resident sat on the floor in front of his/her recliner in the room with his/her walker in the closet. The resident had an armful of clothes. The resident reported he/she fell on his/her knees but could not get up so he/she turned to sit on his/her buttocks. The resident had bruising to left upper arm and left elbow. On the fall investigation form, staff marked a box for care plan updates indicating no new interventions were added on the care plan.<br><br>Observation on 3/23/16 at 9:22 p.m. revealed the resident ambulated in the hall with the hairdresser using a walker. The resident had a slow, shaky gait.<br><br>Observation on 3/23/16 at 2:10 p.m. revealed the resident walked in the halls with his/her walker. The resident wore house slippers with rubber soles on his/her feet. The resident became very anxious and looking for something. Direct care | F 323   |   |                      |   |

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| F 323  | <p>Continued From page 28</p> <p>staff G approached the resident and directed him/her to the afternoon activity but the resident would not stay and continued to ambulate in the halls by him/herself.</p> <p>During an interview on 3/23/16 at 10:30 a.m., direct care staff G reported the resident often became anxious and staff attempted to redirect him/her to an activity or to his/her room and turned the TV on. He/she required assistance with his/her daily care</p> <p>During an interview on 3/23/16 at 4:15 p.m. direct care staff D reported the resident at times needed assistance with transfers. The resident had a fall alarm on his/her bed and fall mat by his/her bed. When the resident walked around, he/she tried to distract the resident and involve him/her in activities. Staff D reported staff supervised the resident but did not do one-on-one supervision with the resident when he/she became anxious. If the resident became anxious, he/she reported to the nurse for the resident's safety.</p> <p>During an interview on 3/28/16 at 10:42 a.m. licensed nurse F reported the resident had a fall mat, a bed alarm and had another chair in his/her room removed. Nurse F reported the nurse on duty was responsible to update the care plan. The changes went on the dashboard to relay changes (opening page of the computer system all staff use to chart). Nurse F reported the director of nurses completed the fall investigation.</p> <p>During an interview on 3/24/16 at 3:10 p.m. administrative nurse A stated he/she fell behind with the fall investigations The nurse stated he/she had not had time to initiate an investigation or update the care plan for the fall</p> | F 323   |   |                      |   |

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| F 323  | Continued From page 29 on 3/15/16.<br><br>Review of the facility ' s policy named Accidents and Incidents revised on 7/10/14 revealed a list of fall interventions and included strategies must be individualized to each resident for each occurrence.<br><br>The facility failed to complete a fall investigation to determine the root cause of the fall to develop and implement fall interventions after falls to prevent further falls.  | F 323   |   |                      |   |
| F 441<br>SS=F  | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 30</p> <p>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<br/>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:<br/>The facility had a census of 27 residents. Based on observation, interview and record review, the facility failed to maintain a clean/sanitary environment for residents when staff failed to follow the manufacturer ' s recommendations for wet times to ensure adequate sanitization/disinfection of resident rooms. This had the ability to affect all residents.</p> <p>Findings included:</p> <p>- During an observation on 3/24/16 at 8:47 AM housekeeping staff I and H sprayed a bottle of yellow liquid (Peroxide Multi-Surface Cleaner/Disinfectant) to moisten a cloth and wiped door knobs, light switches and hand rails in the halls by the nurse ' s station.</p> <p>On 3/24/16 at 9:42 AM, both housekeeping staff I and H entered to clean resident ' s room. Housekeeping staff both applied gloves. Housekeeping staff H moved items from the sink area and sprayed faucet handles, basin and</p> | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 31</p> <p>surrounding area. He/she sprayed the shelf over the television, then the resident ' s bedside table. He/she obtained a dry cloth and wet it with cleaner. He/she wiped the bed control; call light, phone, and alarm clock and cords. Housekeeping staff sprayed the sink surfaces. The chemical pooled on the sink surface when it was sprayed. He/she failed to cover the entire surface of the sink with chemical.</p> <p>Continued observation on 3/24/16 revealed:</p> <p>At 9:54 AM housekeeping staff H wiped the resident ' s sink and areas previously sprayed.</p> <p>At 9:49 AM housekeeping staff I removed bedsheets and blankets and left a cloth mattress pad on the bed. Housekeeping staff I sprayed the mattress pad with DG Home Disinfectant spray that identified a wet time of 10 minutes to disinfect or 5 minutes to sanitize. He/she let the mattress pad air dry. He/she stated he/she would wipe down the mattress if there was no mattress pad on the bed.</p> <p>At 9:50 AM housekeeping staff I used Disinfectant Acid Bathroom Cleaner on exterior surfaces in the bathroom. Housekeeping staff placed toilet bowl cleaner in the toilet bowl and swabbed it immediately. At 9:52 AM housekeeping staff wiped the exterior bathroom surfaces with a rag.</p> <p>At 9:58 AM housekeeping staff H used the rag from the sink on the resident ' s door and door handle. He/she wiped the door areas down. He/she failed to ensure that the area was wet.</p> <p>At 10:00 AM housekeeping staff H removed items</p> | F 441   |   |                      |   |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANTHONY COMMUNITY CARE CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>212 N 5TH AVE<br/>ANTHONY, KS 67003</b>                             |                      |   |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| F 441  | <p>Continued From page 32</p> <p>from the resident ' s over the bed table. He/she sprayed the disinfectant again in spots/streaks but did not wet the entire surface. At 10:02 AM he/she wiped the sprayed surface. Housekeeping staff H pulled trash out of the can , then removed gloves and washed his/her hands.</p> <p>At 10:13 AM housekeeping staff H damp mopped the floor of the resident ' s room with Neutral Disinfectant Cleaner and left it to air dry.</p> <p>At 10:18 AM the floor that he/she mopped first was dry. The entrance to the room was the only location that was wet.</p> <p>Product information for Peroxide Multi-Surface Cleaner/Disinfectant, DG Home Disinfectant and Disinfecting Acid Bathroom Cleaner contained the following information:</p> <p>Peroxide Multi-Surface Cleaner/Disinfectant is used as a broad spectrum disinfectant. It is antibacterial, germicidal and fungicidal. It cleans glass, windows, mirrors, faucets, countertops, stainless steel and shiny surfaces. For bactericidal use the manufacturer identified a wet time for the product as 3 minutes. For virucidal and fungicidal use the manufacturer identified a wet time of 5 minutes.</p> <p>DG Home Disinfectant Spray is a disinfectant that is identified by the manufacturer as having the ability to kill 99.9% of all germs. The product is used on hard, non-porous, non-food contact surfaces. To disinfect hold the can upright and spray from a distance of 6-8 inches until area for treatment is thoroughly moistened. Allow surfaces to remain wet for 10 minutes before wiping.</p> | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 33</p> <p>Interview with housekeeping staff I on 3/24/16 at 10:13 AM revealed he/she got the mop water from the dispenser. The facility used Neutral Cleaner/Disinfectant to mop the floors. Housekeeping staff stated if the product was sudsy then it was right. He/she did not measure concentration of chemical and water. He/she stated the supplier goes out to the facility once a month to check it. He/she identified the Peroxide cleaner and the bathroom cleaner had a wet time of 5 minutes.</p> <p>Interview of housekeeping supervisory staff J on 3/24/16 at 12:30 PM revealed he/she said the facility used a dilution of the chemical that had a 5 minute contact/wet time. He/she explained that entire surface should be wet for 5 minutes. He/she said he/she teaches housekeeping staff how to clean and had not hired any new staff for about 2 years. He/she said that he/she has worked with housekeeping staff and supervised them that way. Housekeeping staff did deep cleanings together. He/she explained that when he/she cleaned door knobs he/she held his/her rag up to stop drips, but sprayed DG Home Disinfectant Spray directly onto the doorknob surface.</p> <p>The facility did not have a policy that identified directions for the use of cleaning agents or adherence to manufacturer wet times.</p> <p>The facility failed to maintain a clean/sanitary environment for residents when staff failed to follow the manufacturer ' s recommendations for wet times to ensure adequate sanitization/disinfection of resident rooms.</p> | F 441   |   |                      |   |