

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

Printed: 07/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER COFFEY COUNTY HOSPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVENUE WAVERLY, KS 66871		
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F 000	INITIAL COMMENTS	F 000		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 27 residents, with 10 selected for review. Based on observation, interview, and record review, the facility failed to accommodate the individual preferences for 1 (#2) of the 2 residents sampled for choices related to bathing options.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #2's signed physician orders, dated 6/8/16, documented admission on 10/23/15, with the following diagnoses including; arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and chronic pain. <p>The admission MDS (minimum data set), dated 10/28/15, revealed the resident had a BIMS (brief interview for mental status) score of 13/15 indicating intact cognition. The resident required physical help of 1 staff for bathing.</p>	F 246		
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 246	<p>Continued From page 1</p> <p>The care plan, dated 10/29/16, guided staff to assist the resident with a whirlpool twice a week.</p> <p>Review of the bathing preference form, dated 10/23/15, evidenced the resident preferred a whirlpool with jets for bathing.</p> <p>Review of the resident's individual shower records, reveled the lack of the type of bathing the resident actually received.</p> <p>On 7/5/16 at 11:12 AM, the resident stated he/she used to get whirlpools, but now only received a shower, and stated he/she really liked the whirlpool for bathing.</p> <p>On 7/7/16 at 3:32 PM, direct care staff C stated the resident received a shower today, and stated he/she should have received a whirlpool, but the shower was faster. Direct care staff C stated he/she always gave the resident a shower, and verified the bath schedule did document the resident liked a whirlpool.</p> <p>On 7/7/16 at 3:58 PM, the resident stated he/she did get a shower this afternoon, and was not asked the preference of a shower or a whirlpool, and stated that staff were aware of the whirlpool preference. The resident stated he/she was never offered a whirlpool any more.</p> <p>On 7/11/16 at 9:58 AM, licensed nursing staff D, stated the shower list had preferences of a shower or a whirlpool, and if the resident chose a different type of bathing, other than what was listed on the sheet, the shower sheet should reflect the different type of bathing the staff provided to the resident.</p> <p>On 7/11/16 at 11:32 AM, administrative nursing</p>	F 246			

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F 246	Continued From page 2 staff A, stated when a resident admitted to the facility, the resident would be interviewed for the type of bathing he/she wanted, and then staff would be notified by placing the bathing choice on the resident's care guide. The facility's policy for bathing preference, dated 09/12, revealed the purpose of the bathing preference was to ensure the resident/family had input into the type of bath given. The facility failed to accommodate the individual preferences for bathing choices for this resident who preferred a whirlpool.	F 246		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on observation and interview, the facility failed to provide housekeeping and maintenance services to maintain a sanitary interior for the residents of the facility, on the 2 resident hallways, the beauty shop, 5 shared bathrooms, and in 12 resident rooms. Findings included: - During the initial tour on 7-05-16 at 8:29 a.m., and an environmental tour on 7-11-16 at 1:03 p.m., with administrative staff A, dietary/housekeeping staff E and maintenance staff F, the following areas were noted to be in need of repair, replacement, or cleaning:	F 253		

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F 253	<p>Continued From page 3</p> <p>East Hall:</p> <ol style="list-style-type: none"> 1.) Three resident rooms had window sills with a build-up of dust and debris. 2.) Two shared resident bathrooms had dark staining around the base of the toilets. 3.) One resident room had a build-up of dust in the air conditioning unit. 4.) One resident room had two ceiling tiles beginning to come down. 5.) One resident room had an air conditioning unit with paint peeling away from it. 6.) One shared resident bathroom had cove base with a gap, making it difficult to sanitize surface. 7.) One resident room had plaster crumbling from the wall and gathering on top of the air conditioning unit. 8.) Two shared resident bathrooms had toilet seat risers which contained a brown discoloration. 9.) Three resident rooms had dead bugs in the window sills. <p>West Hall:</p> <ol style="list-style-type: none"> 1.) One resident's motorized wheelchair had a heavy build-up of food particles and debris on the foot rest. The back and sides of the motorized wheelchair also had areas of dried food substances. 	F 253		

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F 253	<p>Continued From page 4</p> <p>2.) One resident room had oxygen tubing lying directly on the floor at the foot of the bed.</p> <p>3.) Four resident rooms had dark staining around the base of the toilets.</p> <p>4.) A water fountain had a build-up of a green/black substance around the drain and a white substance near the mouth piece.</p> <p>5.) The cove base in the hallway was peeling from the wall in several spots.</p> <p>6.) One resident room had two sticky bug traps on the floor which contained dead spiders and roly poly bugs.</p> <p>7.) One resident room had a cobweb on the side of the wall air conditioning unit which contained numerous dead bugs.</p> <p>8.) One resident room had dead bugs in the window sills.</p> <p>The Beauty Shop:</p> <p>1.) The window had a build-up of dust.</p> <p>2.) A portable hair dryer stand had a heavy build-up of dust and cut hair.</p> <p>3.) A standing hair dryer vent had a very heavy build-up of dust.</p> <p>The facility policy for cleaning the beauty shop, dated 4-03-15, included, every Monday evening the dryer chairs, stand up dryers, blinds and window sill were to be wiped off with quat-stat.</p>	F 253			

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F 253	Continued From page 5 The facility lacked a housekeeping policy. The facility failed to provide maintenance and housekeeping services to maintain the facility residents' environment, in a sanitary and homelike manner for the residents of the facility.	F 253		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility reported a census of 27 residents. The sample for 10 residents included 5 residents reviewed for unnecessary medications. Based on observation, interview, and record review, the	F 329		

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F 329	<p>Continued From page 6</p> <p>facility failed to provide monitoring for medication effectiveness of PRN (as needed) medications administered to 1 (#2) of the 5 residents reviewed.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #2's signed physician orders, dated 6/8/16, documented admission on 10/23/15, with the following diagnoses including; arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and chronic pain. <p>The physician orders included:</p> <ol style="list-style-type: none"> 1.) On 3/20/16, Hydrocodone/apap, (pain medication) 5/325 mg (milligrams), daily, every 4 to 6 hours, prn, for pain. 2.) On 10/23/15, Mylanta, 30 ml (milliliter), every 4 hours, as needed for Gastro esophageal reflux (backflow of stomach contents to the esophagus). 3.) On 12/7/15 Zofran, (anti-nausea)4 mg, by mouth, every 6 hours as needed for nausea. <p>Review of the MARs (medication administration records), from 3/1/16 to 7/7/16 evidenced the following:</p> <p>On 4/16/16, Hydrocodone 5/325 mg. administered twice, and lacked documentation follow-up of the medication effectiveness for 1 of the 2 times administered.</p> <p>On 4/21/16, the front of the MAR revealed Hydrocodone 5/325 mg. administered twice, and</p>	F 329			

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F 329	<p>Continued From page 7</p> <p>lacked follow-up documentation with the medication effectiveness for 1 of the 2 administration times.</p> <p>Review of the April, 2016, MAR, revealed the resident received Zofran 4 mg. on 4 occasions, and lacked follow-up for effectiveness of the medication for 2 of the 4 opportunities.</p> <p>Review of the June, 2016, MAR, documented the administration of Hydrocodone 5/325 mg, prn, on 30 occasions. The record lacked documentation for any follow-up of the medications effectiveness for 10 of the 30 times administered.</p> <p>On 6/5/16, staff administered Zofran 4 mg. to the resident but failed to complete any follow-up monitoring of the medications effectiveness.</p> <p>The June, 2016, MAR, documented staff administered Mylanta, 30 ml, on 3 occasions, and failed to complete any follow-up for effectiveness on 1 of the 3 times administered.</p> <p>The July, 2016, MAR, documented on 7/2/16, staff administered Hydrocodone 5/325 mg, and failed to complete any follow-up for effectiveness of the medication administered.</p> <p>On 7/7/16 at 2:33 PM, direct care staff B, reported the prn medications should be charted in the MAR, and follow-up of the effectiveness should be made on the back of the MAR.</p> <p>On 7/11/16 at 9:58 AM, licensed nursing staff D, stated if a resident had pain, the nurse would assess the resident, document the prn medication on the front of the MAR, and document the date, time, medication, dosage, and follow-up for effectiveness. Licensed nursing</p>	F 329			

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F 329	<p>Continued From page 8</p> <p>staff D verified sometimes the medication was not followed-up on for effectiveness.</p> <p>On 7/11/16 at 11:32 AM, Administrative nursing staff A, stated if a resident complained of pain, the nurse would assess the pain, and give prn medications. Nurses would document on the front of the MAR, then on the back of the MAR of the medication administered, rate the pain, and follow-up on the effectiveness of the pain medication.</p> <p>The facility's policy for administration and documentation of medications, dated 2/2012, explained prn medication would be documented on the front of the MAR and initialed and documented on the back of the MAR for the response to the medication. Response should be documented within 1 hour after the administration of a medication.</p> <p>The facility failed to adequately monitor the effectiveness of these 3 prn medications administered to this resident to ensure the medications effectiveness.</p>	F 329		
F 363 SS=D	<p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 27, and identified 1 resident on a pureed diet. Based on observation, interview, and record review, the</p>	F 363		

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F 363	<p>Continued From page 9</p> <p>facility failed to follow the planned menu and recipe for the 1 resident who received a pureed diet, to ensure the resident maintained acceptable nutritional values.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 7-11-16 at 10:47 a.m., dietary staff H prepared the pureed BBQ (barbeque) chicken. Staff H added some BBQ chicken, a slice of bread and some milk to the food processor. Staff H continued to add milk to the mixture until it was at the proper, pureed texture and consistency. <p>The facility recipe for ham, turkey, chicken, beef, pork, or veal, dated 12/12, included to add broth or gravy as the liquid to reach the desired consistency.</p> <p>On 7-11-16 at 11:20 a.m., dietary staff H stated, he/she does not always look at the recipe before preparing the pureed food and does not always measure or weigh the food before preparing the pureed meals. He/she had not done so with the pureed meal for lunch on that day. Staff H also stated that he/she did not know where the recipe for the pureed diet for the lunch meal was located or how to read it once it was located.</p> <p>On 7-11-16 at 11:46 a.m., dietary staff E stated, staff H is an "old hat" at cooking and doesn't always need to look at the recipes. Staff E stated he/she had no idea how to read the recipe for the pureed diet for that days lunch either.</p> <p>The facility lacked a policy for preparation of pureed foods.</p> <p>The facility failed to follow the planned menu and recipe to ensure acceptable nutritional values</p>	F 363		

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F 363	Continued From page 10 were met for the 1 resident who received the pureed diet.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on observation and interview, the facility failed to store, prepare, and serve food under sanitary conditions to prevent the spread of food borne illnesses to the residents of the facility. Findings included: - On 7-05-16 at 8:29 a.m., during the initial tour, and on 7-11-16, during the dietary tour with dietary staff E, the following areas of concerns were revealed: 1.) Shelving units holding plastic containers contained rust along the edges and legs. 2.) A plastic lid had a large cracked area in the center, making it unsanitizable. 3.) The window sill above the dish washing sink had a heavy build-up of dust and debris. 4.) The handle of the reach in refrigerator was	F 371		

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F 371	Continued From page 11 broken. 5.) The racks inside of the refrigerator had plastic coating which was peeling off in several areas making the racks unsanitizable. 6.) The refrigerator had a build-up of food debris and other debris in the corners by the hinges. 7.) There was dried food across the front of the refrigerator. 8.) The plastic cart, used for the ice chest, had various cracked/broken areas, making it unsanitizable. 9.) The ice machine vent had a heavy build-up of dust. 10.) The top shelves in the kitchen area had a build-up of dust. 11.) The inside of the microwave door had a sticky substance. 12.) The inside of the toaster was dirty and had crumbs on the collection tray. 13.) Nineteen red and brown serving trays were heavily scratched, making them an unsanitizable surface. 14.) Six spice bottles had a sticky substance covering them with soiled tops. 15.) The vent in the ceiling by the stove had a brown stain. 16.) The kitchen ceiling was dripping water in multiple areas.	F 371			

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F 371	Continued From page 12 17.) The dish washing table legs and pipes underneath the dish washer had a heavy build-up of food debris and a dark, wet, goeey substance. 18.) The large stand mixer had dried food splatters on and around the base. 19.) The table holding the stand mixer had a heavy build-up of dust and dried food substance. Review of the current kitchen cleaning schedule, revealed there were several spaces left unmarked, indicating multiple areas of the scheduled cleaning had not been completed. On 7-11-16 at 2:30 p.m., dietary staff E acknowledged there were several places on the cleaning schedule which staff failed to complete. He/she stated not all of the staff saw the importance in keeping the kitchen clean. The facility lacked a policy on cleaning of the kitchen. The facility failed to store, prepare, and serve food under sanitary conditions for the residents of the facility.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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(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 428	Continued From page 13 This Requirement is not met as evidenced by: The facility reported a census of 27 residents. The sample for 10 residents included 5 residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility's pharmacist failed to identify the facility irregularity of the failure to monitor the the effectiveness of medications with follow-up of PRN (as needed) medications for 1 (#2) of the 5 residents reviewed. Findings included: - Resident #2's signed physician orders, dated 6/8/16, documented admission on 10/23/15, with the following diagnoses including; arthritis (inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), and chronic pain. The physician orders included: 1.) On 3/20/16, Hydrocodone/apap, (pain medication) 5/325 mg (milligrams), daily, every 4 to 6 hours, prn, for pain. 2.) On 10/23/15, Mylanta, 30 ml (milliliter), every 4 hours, as needed for Gastro esophageal reflux (backflow of stomach contents to the esophagus). 3.) On 12/7/15 Zofran, (anti-nausea)4 mg, by mouth, every 6 hours as needed for nausea. Review of the MARs (medication administration records), from 3/1/16 to 7/7/16 evidenced the	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
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F 428	<p>Continued From page 14 following:</p> <p>On 4/16/16, Hydrocodone 5/325 mg. administered twice, and lacked documentation follow-up of the medication effectiveness for 1 of the 2 times administered.</p> <p>On 4/21/16, the front of the MAR revealed Hydrocodone 5/325 mg. administered twice, and lacked follow-up documentation with the medication effectiveness for 1 of the 2 administration times.</p> <p>Review of the April, 2016, MAR, revealed the resident received Zofran 4 mg. on 4 occasions, and lacked follow-up for effectiveness of the medication for 2 of the 4 opportunities.</p> <p>Review of the June, 2016, MAR, documented the administration of Hydrocodone 5/325 mg, prn, on 30 occasions. The record lacked documentation for any follow-up of the medications effectiveness for 10 of the 30 times administered.</p> <p>On 6/5/16, staff administered Zofran 4 mg. to the resident but failed to complete any follow-up monitoring of the medications effectiveness.</p> <p>The June, 2016, MAR, documented staff administered Mylanta, 30 ml, on 3 occasions, and failed to complete any follow-up for effectiveness on 1 of the 3 times administered.</p> <p>The July, 2016, MAR, documented on 7/2/16, staff administered Hydrocodone 5/325 mg, and failed to complete any follow-up for effectiveness of the medication administered.</p> <p>On 7/7/16 at 2:33 PM, direct care staff B, reported the prn medications should be charted in</p>	F 428			

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

Printed: 07/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/14/2016
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F 428	<p>Continued From page 15</p> <p>the MAR, and follow-up of the effectiveness should be made on the back of the MAR.</p> <p>On 7/11/16 at 9:58 AM, licensed nursing staff D, stated if a resident had pain, the nurse would assess the resident, document the prn medication on the front of the MAR, and document the date, time, medication, dosage, and follow-up for effectiveness. Licensed nursing staff D verified sometimes the medication was not followed-up on for effectiveness.</p> <p>On 7/11/16 at 11:32 AM, Administrative nursing staff A, stated if a resident complained of pain, the nurse would assess the pain, and give prn medications. Nurses would document on the front of the MAR, then on the back of the MAR of the medication administered, rate the pain, and follow-up on the effectiveness of the pain medication.</p> <p>The facility's policy for administration and documentation of medications, dated 2/2012, explained prn medication would be documented on the front of the MAR and initialed and documented on the back of the MAR for the response to the medication. Response should be documented within 1 hour after the administration of a medication.</p> <p>On 07/11/2016 at 1:05 PM, consultant staff I, stated he/she did not check the MARS monthly, and would only glance at the MAR's randomly to check for the staff's written response to the prn medications. He/she verified the medication was to be documented on the front of the MAR, and then chart the effectiveness of the prn medication on the back.</p> <p>The facility pharmacist failed to identify the facility</p>	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2016
NAME OF PROVIDER OR SUPPLIER COFFEY COUNTY HOSPITAL LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 128 S PEARSON AVENUE WAVERLY, KS 66871		
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F 428	Continued From page 16 irregularity to adequately monitor the effectiveness of these 3 prn medications administered to this resident to ensure the medications effectiveness.	F 428		
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, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2016
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F 441	<p>Continued From page 17 infection.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on 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 to identify a trend in infections and antibiotic use, for the residents of the facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the facility's monthly infection control logs, from August, 2015, through current, revealed the following: 1.) The source of infections as nosocomial (hospital acquired)/community (acquired outside of a healthcare setting) was not indicated from July, 2015, through present. 2.) The facility lacked any infection control monitoring for July, 2015. 3.) The August, 2015, log identified 4 infections, without any culture results and trends. 4.) The September, 2015, Quality Assurance report documented 4 infections and lacked a monthly log. 5.) The facility lacked any infection control monitoring for October, 2015, November, 2015 and December, 2015. 6.) The January, 2016, Infection Monitoring Year to date 2016 report, identified 4 infections and 	F 441		

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

Printed: 07/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2016
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F 441	Continued From page 18 lacked logs. 7.) The February, 2016, log identified 9 infections and lacked culture results and trends. 8.) The March, 2016, log identified 14 infections and lacked culture results and trends. 9.) The April, 2016, log identified 5 infections and lacked culture results and trends. 10.) The May, 2016, log identified 4 infections and lacked culture results and trends. 11.) The June, 2016, log identified one infection and lacked culture results and trends. Interview on 7/11/2016 at 11:00 am, with Administrative Nursing Staff A, revealed he/she acknowledged that he/she should record culture results on the monthly logs. Trending of infections in the facility should include culture results, antibiotic usage and trends related to the identified infections. 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 by failing to trend infections and antibiotic use.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This Requirement is not met as evidenced by:	F 463		

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

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F 463	<p>Continued From page 19</p> <p>The facility reported a census of 27 residents. Based on observation and interview, the facility failed to maintain call lights in proper working order to ensure availability of staff assistance to the residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - While checking call lights on 7-06-16 at 8:44 a.m., one of the call lights in room 4 failed to work. <p>On 7-05-16 at 3:30 p.m., the resident was in his/her room resting in bed. The resident had two call lights in his/her room, one was a regular push-button call light and the other a touch pad call light. The push-button call light was attached to the resident's blankets, near his/her hand.</p> <p>On 7-06-16 at 8:44 a.m., administrative nursing staff A, after notification of the call light in room 4 not working properly, reported he/she would notify the appropriate staff member (Maintenance staff E) of the problem.</p> <p>On 7-06-16 at 8:55 a.m., direct care staff J and K stated, the resident used the push button call light while he/she is in bed and the touch pad call light when he/she is up in the recliner.</p> <p>On 7-07-16 at 9:19 a.m., the call light in room 4 continued to not function properly. Maintenance staff E stated he/she had forgotten to change the call light when he/she had been notified of the problem the day before. Staff E changed the call light at that time and it then functioned properly to alert staff of the resident in need of assistance.</p> <p>On 7-11-16 at 3:33 p.m., Staff E reported checking the call lights on a monthly basis and</p>	F 463			

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F 463	Continued From page 20 provided documentation showing the call lights had been checked on 6-23-16, and had been working properly at that time. The facility lacked a policy regarding checking call lights for proper working condition. The facility failed to maintain functional call lights in proper working condition for this resident to notify staff timely of any needs required of staff assistance.	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This Requirement is not met as evidenced by: The facility had a census of 27 residents. Based on observation and interview, the facility failed to provide a sanitary environment for residents and staff in the facility kitchen area. Findings included: - On 7-05-16 at 8:29 a.m., during the initial tour, and on 7-11-16, during the dietary tour with dietary staff E, the following areas of concerns were revealed: 1.) The parameter of the kitchen floor had a very heavy build-up of food and debris. 2.) The cove-base underneath the dish machine was peeling off away from the wall and lying on the floor in one area.	F 465		

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

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F 465	Continued From page 21 On 7-11-16 at 10:30 a.m., dietary staff E stated, the floor was supposed to have been replaced several years ago, but had not been. However, the staff could do a better job of sweeping. The facility lacked a policy regarding cleaning the kitchen. The facility failed to provide a sanitary environment for residents and staff in the facility kitchen area.	F 465		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This Requirement is not met as evidenced by: The facility reported a census of 27 residents. Based on observation, record review and interview, the facility failed to maintain an effective pest control program to ensure the facility was free of pests/bugs in the residents' environment. Findings included: - During the initial tour on 7-05-16 at 8:29 a.m., and an environmental tour on 7-11-16 at 1:03 p.m., with administrative nursing staff A, dietary/housekeeping staff E and maintenance staff F, revealed several bugs throughout the building, including: 1.) Three resident rooms on the east hall had live bugs in the window sills.	F 469		

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

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F 469	<p>Continued From page 22</p> <p>2.) One room on west hall had live bugs in the window sills.</p> <p>On 7-05-16 at 12:58 p.m., a resident stated there are a lot of bugs in the building all of the time, including big spiders. He/she had a big spider in their shoe the other day when they were getting dressed.</p> <p>On 7-11-16 at 1:03 p.m., administrative nursing staff A stated, pest control comes and sprays inside of the building on a monthly basis.</p> <p>On 7-11-16 at 1:03 p.m., housekeeping supervisor staff E stated, wolf spiders have been reported to him/her. Wolf spiders are all over the building, with more being seen at night.</p> <p>On 7-11-16 at 1:03 p.m., maintenance staff F stated, he/she will discuss with pest control what more can be done for the spiders.</p> <p>The facility failed to provide effective pest control measures to provide a pest free comfortable environment for the residents of the facility.</p>	F 469		