

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

PRINTED: 07/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		
(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 000	INITIAL COMMENTS	F 000			
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <ul style="list-style-type: none"> - On 7/09/2012 at 12:32 PM, observation revealed Nurse Aide C rolled his/her stool from one table to another and assisted a resident at the other table in the dining room to eat his/her meal. Nurse Aide C then wheeled the stool back to the first table and assisted a resident at that table to eat. Further observation revealed Nurse Aide F relieved Nurse Aide C and cut up a resident's sloppy joe. Nurse C returned to the table to assist two residents at the first table to eat. <p>On 7/16/12 at 1:58 PM, Dietary Staff B verified the staff should be seated next to the residents that require extensive assist with eating/drinking and provide assist as needed. Dietary Staff B verified the staff should not assist multiple residents with extensive assistance or roll between tables to provide resident with needed assistance.</p> <p>The facility's Protecting Patient and Resident</p>	F 241			

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 241	<p>Continued From page 1</p> <p>Rights policy, dated 1/13/2009, stated the facility will ensure that adequate number of staff are scheduled to be able to appropriately care for the residents and/or patients.</p> <p>Although these residents may be cognitively impaired, most reasonable people in our culture would find this experience to be very demeaning.</p> <p>The facility failed to promote dignity for the residents that are assisted with dining.</p> <p>The facility had a census of 35 residents. The sample included 15 residents. Based on observation, interview and record review, the facility failed to promote care for residents in a manner that maintains or enhances each resident's dignity in 1 of 1 facility dining rooms.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 7/9/12 at 12:11 PM, observation revealed resident #15 receiving an insulin injection administered by Nurse D, in the dining room of the facility. During the observation several other residents who reside in the facility were in the dining room in full view of the nurse administering the injection to the resident. <p>On 7/16/12 at 3:30 PM, Nurse A verified the staff should not administer injections/provide procedures in the dining room in full view of the other residents.</p> <p>Review of the facility's Policy and Procedure on Med Pass revealed the staff are directed to give</p>	F 241			

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F 241	Continued From page 2 medications as ordered.	F 241			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility failed to promote care for Resident #15 in a manner to maintain and enhance dignity and respect. 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. This REQUIREMENT is not met as evidenced by: The facility had a census of 35 residents. The sample included 15 residents of which 3 were reviewed for physical restraints. Based on observation, record review and interview the facility failed to ensure side rails were properly maintained and assessed to prevent accident hazards for 3 of 3 sampled residents. (#22, #36 and #16) Findings included: - Resident #22's annual (MDS) Minimum Data Set 3.0 assessment, dated 06/06/12, indicated the resident had short and long term memory problems and moderately impaired decision making skills. The MDS also indicated the resident required total assistance with bed mobility and transfers. The MDS further indicated the resident was a fall risk.	F 323			

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F 323	<p>Continued From page 3</p> <p>The 06/04/12 Side Rail Rationale assessment indicated the resident had a history of falls from his/her bed. The assessment also indicated the resident had poor balance and trunk control and the side rails prevented the resident from rolling out of bed.</p> <p>The 06/07/12 care plan directed the staff to provide total care for all the resident's (ADLs) activities of daily living. The care plan also directed the staff to use a side rail to prevent the resident from falling out of bed.</p> <p>On 07/16/12 at 8:10 AM, observation revealed the resident's bed had a 1/2 side rail on the bottom section of the bed. Continued observation revealed the side rail was not adequately secured to the bed and moved back and forth to touch. Continued observation revealed the movement of the loose side rail created a 5-6 inch hazardous gap between the side rail and mattress.</p> <p>On 07/16/12 at 8:10 AM, Nurse E stated the resident's side rail was not secure and moved back and forth with touch. Nurse E also stated the resident's side rail movement created unsafe gaps between the mattress and side rail. Nurse E further stated the gaps were a potential accident hazard for the resident.</p> <p>The April 2010 Side Rail Policy directed the staff to perform an on-going assessment to prevent accident hazards, such as, gaps in the side rail and/or between the mattress and the side rail.</p> <p>The facility failed to ensure the side rail was properly maintained to prevent hazardous gaps</p>	F 323			

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F 323	<p>Continued From page 4 for Resident #22.</p> <p>- Resident #36's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 05/23/12, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 13 (cognitively intact). The MDS also indicated the resident required total assistance with bed mobility and transfers. The MDS further indicated the resident was a risk for falls.</p> <p>The 05/21/12 Side Rail Rationale assessment indicated the resident had poor balance and trunk control. The assessment also indicated the resident used the side rails for safety and to enhance his/her bed mobility.</p> <p>The 05/24/12 care plan indicated the resident was a high risk for falls due to his/her poor safety awareness and restless movement in bed. The care plan directed the staff to use side rails to enhance the resident's bed mobility and prevent the resident from falling out of bed.</p> <p>On 07/09/12 at 3:31 PM, observation revealed the resident resting quietly in bed. Continued observation revealed the top and bottom side rails raised on both sides of the resident's bed. Continued observation revealed the top rails with four - 7 inch by 8 inch gaps (large enough for the resident's extremities to fit through) and the bottom rails with three - 7 inch by 8 inch gaps. Continued observation revealed a 7-8 inch gap (large enough for the resident's head to fit through) between the top and bottom side rails.</p> <p>On 07/09/12 at 3:41 PM, Nurse A stated the resident's side rails had gaps the resident could</p>	F 323			

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F 323	<p>Continued From page 5</p> <p>fit his/her head and extremities through. Nurse A also stated the side rail gaps were a potential accident hazard for the resident.</p> <p>The April 2010 Side Rail Policy directed the staff to perform an on-going assessment to prevent accident hazards, such as, gaps in the side rail and/or between the mattress and the side rail.</p> <p>The facility failed to adequately assess hazardous gaps in the side rails for Resident #36.</p> <p>- Resident #16 quarterly (MDS) Minimum Data Set 3.0 assessment, dated 5/23/2012, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 14 which indicated the resident was cognitively intact memory. The MDS indicated the resident required extensive staff assistance of 2 for transfers and bed mobility and used a restraint used daily.</p> <p>The (CAAs) Care Area Assessment dated 5/23/2012, indicated the resident requested the side rails to transfer and reposition in his/her bed.</p> <p>On 7/09/2012 at 2:30 PM, observation revealed the resident, seated in his/her wheelchair, in his/her room. Further observation revealed the resident had a half side rail in the up position. Continued observation revealed the side rail had a 5 to 7 inch gap from the bed to the side rail. The side rail was wobbly loose and not appropriately screwed on to the bed frame.</p> <p>The facility's April 2010 Bed Safety Policy</p>	F 323			

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F 323	Continued From page 6 directed one staff stated to perform an on-going assessment of the patient's physical and mental status and closely monitor high risk patients. The policy directed the staff to consider the following: 1) Lower one or more sections of the bed rail, such as foot rail 2) Use a proper size mattress or mattress with raised foam edges to prevent patients from being trapped between the mattress and the rail. 3) Reduce the gaps between the mattress and the side rail. On 7/11/2012 at 10:25 AM, Nurse G verified the half side rails on the resident's bed were loose and had not been secured to the bed frame and the gap would allow a resident to get his/her head or other body part through the openings. Nurse A verified the facility had not assessed the side rails for safety. Continued interview revealed the facility lacked adequate monitoring of the rails for proper fit and safety on a daily basis. The facility failed to thoroughly assess Resident #16's bed side rails for safety.	F 323			
F 371 SS=E	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	F 371			

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F 371	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 35 residents. The sample included 15 residents. Based on observation and interview the facility failed to distribute and serve food under sanitary conditions for the 35 residents who reside in the facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 07/09/12 at 12:22 PM, observation revealed Dietary Staff M wore gloves and served lunch to the residents. Continued observation revealed Dietary Staff M touched multiple wheelchair handles, dining room chairs, residents' clothing and residents' tableware without changing his/her gloves. Continued observation revealed Dietary Staff M handled several resident's dinner rolls (sliced and buttered) without changing his/her soiled gloves. <p>On 07/16/12 at 1:58 PM, Dietary Staff B stated the dietary staff had been educated and trained to use infection control techniques when the staff served and assisted residents with meals. Dietary Staff B stated the staff should not touch the resident's food while serving the meal or providing assistance with foods or drinks.</p> <p>The facility failed to distribute and serve food under sanitary conditions for the 35 residents who reside in the facility.</p>	F 371			