

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

PRINTED: 11/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2016
NAME OF PROVIDER OR SUPPLIER SMITH CENTER OPERATOR, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 117 W 1ST STREET #369 SMITH CENTER, KS 66967		
(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157			

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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 44 residents. The sample included 3 residents. Based on observation, interview, and record review the facility failed to notify the physician of 1 of 3 sampled residents, who had a change in condition, and a decline in physical and mental status related to symptoms of a (UTI) urinary tract infection. (#1)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's quarterly (MDS) Minimum Data Set Assessment, dated 9/24/16, revealed the resident had severe cognitive impairment, inattention, disorganized thinking, psychomotor retardation, (a visible slowing of physical activity such as movement and speech) and occasionally refused care from the facility staff. The MDS further revealed the resident required extensive assistance of 1 to 2 staff for his/her (ADLs) Activities of Daily Living, had range of motion impairment in both lower extremities, and had frequent urinary incontinence. <p>The urinary incontinence (CAA) Care Area Assessment, dated 1/11/16, revealed the resident had bladder incontinence due to poor mobility, urge incontinence, and cognitive impairment. The CAA revealed the most recent 3 day voiding trial revealed the resident did not have a pattern for urinating.</p> <p>The 6/30/16 care plan identified bladder incontinence and directed staff to use disposable briefs, change when soiled, check the resident</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>with toileting, and wash, rinse, and dry the perineum (the area between the anus and scrotum in a male). The care plan further directed staff to monitor for signs and symptoms of a (UTI) urinary tract infection, such as burning, blood tinged urine, cloudiness, foul odor, and no output. The care plan stated the resident could inform staff if he/she needed to use the bathroom and directed staff to assist the resident to the bathroom upon waking, before and after meals, at bedtime, and upon the resident's request. The 10/12/16 updated care plan stated the urinary incontinence goal for the resident was to be free of skin breakdown. The care plan directed the staff to check and change the resident after he/she awoke, and assist him/her to the bathroom as often as he/she desired, even if it is every 30 minutes.</p> <p>The 1/11/16 at 10:20 AM, urine culture report revealed enterobacter aerogenes (infection causing bacteria in the urine).</p> <p>The medical record revealed on 1/12/16, the facility notified the physician of the urine culture report. The physician order directed staff to administer Macrobid (antibiotic for UTI), 100 (mg) milligrams, by mouth, for 10 days.</p> <p>The 1/14/16 physician order directed staff to administer Cipro 500 mg, by mouth, for 7 days.</p> <p>The Bladder Incontinence Evaluation, dated 9/23/16, revealed Resident #1's history of UTIs, concentrated urine, and urinary frequency. The evaluation directed staff to apply adult briefs on</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>the resident, and to check and change the resident only at his/her request.</p> <p>The 9/30/16 at 6:11 AM, 3 day voiding trial included prompted voiding, and stated the resident had frequent incontinent episodes. The assessment conclusion stated because of the resident's confusion, he/she could not be bladder trained.</p> <p>On 10/3/16 at 12:58 PM, the physician order directed staff to administer Zyprexa (antipsychotic medication), 5 mg, daily.</p> <p>On 10/5/16, a urinalysis revealed the resident had a UTI, with a culture that grew proteus mirabilis (infection causing bacteria in the urine).</p> <p>The 10/5/15 at 1:18 PM, physician order directed staff to administer Keflex (antibiotic medication), 500 mg, by mouth, for 7 days.</p> <p>On 10/12/16, review of the (MAR) Medication Administration Record revealed Resident #1 completed the course of Keflex, administered for a urinary tract infection.</p> <p>The 10/18/16 at 11:57 PM, progress note stated the resident had attempted to get out of bed every hour since 8:00 PM, stating he/she wanted to hitch a ride maybe he/she would not get into trouble if he/she found someone to take him/her out of here.</p>	F 157			

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F 157	Continued From page 4 On 10/19/16 at 11:12 PM, the physician progress note stated he/she performed a psychiatric medication review of the resident's medications. The physician stated over the last month, he/she increased the Zyprexa due to the resident's behaviors and delusions. The physician progress note did not address the physical symptoms of a UTI. The 10/20/16 at 12:04 AM, progress note stated the resident did not make sense, and his/her urine started to smell again. The staff questioned if the resident needed to have a urinalysis (test for UTI) and the staff member reported the information to a nurse on shift. The medical record revealed the staff did not obtain a follow-up urinalysis and notify the physician of the resident change in condition, confusion, and foul smelling urine. The 10/24/16 at 1:31 PM, progress note stated the resident's urine still had a foul odor, and was tea colored. The 10/25/16 at 8:19 PM, progress note indicated staff reported the resident continued to have poor oral intake of food and fluids. The note stated the medication aide reported the resident continued to have dark, foul smelling urine. The 10/28/16 at 4:00 AM, progress note indicated the resident's temperature of 99.2 (F) Fahrenheit to the oncoming nurse. The medical record	F 157			

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F 157	<p>Continued From page 5</p> <p>revealed the staff did not report the resident's temperature to the physician.</p> <p>The 11/1/16 at 4:52 PM, progress note stated an aide reported to the nurse the resident's urine smelled terrible, and the resident was confused. The note indicated the nurse recorded the resident's temperature as 99.5 F and no documentation the staff notified the physician of the resident's urine odor, confusion, and temperature.</p> <p>The 11/5/16 at 5:38 AM, progress note stated the resident had dark, foul smelling urine.</p> <p>Review of the medical record revealed no documentation the staff notified the physician regarding the resident's change of condition from 10/18/16 to 11/9/16, although the resident experienced symptoms of a UTI, and increased confusion.</p> <p>The 11/9/16 at 2:45 AM, progress note indicated a standing order was written for a urinalysis due to the resident's dark amber urine, with a strong odor.</p> <p>The 11/9/16 at 5:35 AM, progress note stated the nurse catheterized the resident to obtain a sample of the dark amber, foul smelling urine for testing.</p> <p>The 11/10/16 at 10:51 AM urinalysis revealed the</p>	F 157			

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F 157	<p>Continued From page 6</p> <p>urine was yellow, cloudy, a trace amount of ketones (a substance made by the body when there is not enough urine in the blood), positive for nitrates (a test used to determine the type of bacteria in a urinary tract infection), 6-10 red blood cells, too many white blood cells to count, and packed bacteria.</p> <p>On 11/8/16 at 4:04 PM, observation revealed Nurse Aide D and Nurse Aide E entered the resident's room to check and change the resident for urinary incontinence. The aides removed the incontinence pad, which had a small green/brown area of bowel movement toward the back of the pad, and a large amount of urine soaked into the pad, observation as a brown to tan colored urine stain on the pad. Nurse Aide E cleaned the stool from the resident's coccyx, then with the same soiled glove on, applied barrier ointment to the open area on his/her scrotum. Both staff members removed his/her soiled gloves, and applied a clean pad.</p> <p>On 11/9/16 at 9:18 AM, observation revealed Nurse Aide F and Nurse Aide G assisted the resident to the commode. The pad revealed the resident was incontinent of bowel movement. Nurse Aide F attempted to clean the resident from the front with wet wipes, and tried to wipe downward, unable to visualize the skin area being wiped. He/she had difficulty getting the wipe in the groin area, and at one point wiped upward and circled the top of the groin with the wipe. Further observation revealed the nurse aides failed to offer the resident a drink of water during the cares, from the water pitcher which was located on the nightstand behind the head board of the</p>	F 157			

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F 157	<p>Continued From page 7 resident's bed, out of his/her reach.</p> <p>On 11/8/16 at 4:15 PM, Nurse Aide D stated the resident's urine has smelled horrible for a long time, describing the urine as tan colored and dirty looking.</p> <p>On 11/9/16 at 9:58 AM, Nurse H stated the facility process was to utilize the physician's standing orders to obtain a urinalysis from the resident exhibiting symptoms of UTI. Nurse H stated the nurses would either fax or call the urinalysis results to the physician, who would start the resident on an antibiotic medication to treat the infection. Nurse H stated the facility would typically obtain a follow-up urinalysis after completion of the antibiotic, if the resident began exhibiting symptoms again. Nurse H stated he/she did not know why staff failed to inform the physician, and did not utilize the standing orders to collect another urinalysis sample for testing.</p> <p>On 11/9/16 at 4:30 PM, Administrative Nurse A verified the nurse should perform an assessment when staff report symptoms, and based on the assessment, report any negative findings to the physician. Administrative Nurse A acknowledged the staff did not notify the physician of the resident's change in condition from 10/20/16 to 11/9/16.</p> <p>On 11/14/16 at 4:38 PM, Physician I stated staff should notify him/her in a timely manner, anytime a resident has a change in condition, including symptoms of a UTI. Physician I stated a follow-up urinalysis should be done after completion of an antibiotic if the resident continues to exhibit</p>	F 157			

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F 157	Continued From page 8 symptoms of the infection. The facility's November 2012, Change in a Resident's Condition or Status policy stated the facility shall promptly notify the resident, his or her attending physician, and representative, of changes in the resident's medical/mental condition and/or status. The charge nurse will notify the resident's attending physician or the on-call physician when there has been a significant change in the resident's physical/emotional/mental condition and a need to alter the resident's medical treatment significantly. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status. The facility failed to notify the physician of a change in Resident #1's condition, who had a decline in physical and mental status related to symptoms of a UTI, placing the resident at risk for further decline without medical attention.	F 157			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315			

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F 315	<p>Continued From page 9 function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 44 residents. The sample included 3 residents. Based on observation, interview and record review the facility failed to ensure proper treatment and services to prevent urinary tract infections when the staff failed to perform timely assessment, notify the physician of urinary tract infection symptoms, and provide appropriate perineal cleansing for 2 of 3 residents sampled residents reviewed for urinary incontinence. (#1, #2)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident # 1's medical record included diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask like faces, shuffling gait, muscle rigidity and weakness) and urgency of urination (involuntary passage of urine occurring soon after a strong sense of urgency to void). <p>Resident #1's quarterly (MDS) Minimum Data Set Assessment, dated 9/24/16, revealed the resident had severe cognitive impairment, inattention, disorganized thinking, psychomotor retardation, (a visible slowing of physical activity such as movement and speech) and occasionally refused care from the facility staff. The MDS further revealed the resident required extensive assistance of 1 to 2 staff for his/her (ADLs) Activities of Daily Living, had range of motion</p>	F 315			

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F 315	<p>Continued From page 10</p> <p>impairment in both lower extremities, and had frequent urinary incontinence.</p> <p>The urinary incontinence (CAA) Care Area Assessment, dated 1/11/16, revealed the resident had bladder incontinence due to poor mobility, urge incontinence, and cognitive impairment. The CAA revealed the most recent 3 day voiding trial revealed the resident did not have a pattern for urinating.</p> <p>The 6/30/16 care plan identified bladder incontinence and directed staff to use disposable briefs, change when soiled, check the resident with toileting, and wash, rinse, and dry the perineum (the area between the anus and scrotum in a male). The care plan further directed staff to monitor for signs and symptoms of a (UTI) urinary tract infection, such as burning, blood tinged urine, cloudiness, foul odor, and no output. The care plan stated the resident could inform staff if he/she needed to use the bathroom and directed staff to assist the resident to the bathroom upon waking, before and after meals, at bedtime, and upon the resident's request. The 10/12/16 updated care plan stated the urinary incontinence goal for the resident was to be free of skin breakdown. The care plan directed the staff to check and change the resident after he/she awoke, and assist him/her to the bathroom as often as he/she desired, even if it is every 30 minutes.</p> <p>The 1/11/16 at 10:20 AM, urine culture report revealed enterobacter aerogenes (infection causing bacteria in the urine).</p>	F 315			

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F 315	Continued From page 11 The medical record revealed on 1/12/16, the facility notified the physician of the urine culture report. The physician order directed staff to administer Macrobid (antibiotic for UTI), 100 (mg) milligrams, by mouth, for 10 days. The 1/14/16 physician order directed staff to administer Cipro 500 mg, by mouth, for 7 days. The Bladder Incontinence Evaluation, dated 9/23/16, revealed Resident #1's history of UTIs, concentrated urine, and urinary frequency. The evaluation directed staff to apply adult briefs on the resident, and to check and change the resident only at his/her request. The 9/30/16 at 6:11 AM, 3 day voiding trial included prompted voiding, and stated the resident had frequent incontinent episodes. The assessment conclusion stated because of the resident's confusion, he/she could not be bladder trained. On 10/3/16 at 12:58 PM, the physician order directed staff to administer Zyprexa (antipsychotic medication), 5 mg, daily. On 10/5/16, a urinalysis revealed the resident had a UTI, with a culture that grew proteus mirabilis (infection causing bacteria in the urine). The 10/5/15 at 1:18 PM, physician order directed	F 315			

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F 315	<p>Continued From page 12</p> <p>staff to administer Keflex (antibiotic medication), 500 mg, by mouth, for 7 days.</p> <p>On 10/12/16, review of the (MAR) Medication Administration Record revealed Resident #1 completed the course of Keflex, administered for a urinary tract infection.</p> <p>The 10/18/16 at 11:57 PM, progress note stated the resident had attempted to get out of bed every hour since 8:00 PM, stating he/she wanted to hitch a ride maybe he/she would not get into trouble if he/she found someone to take him/her out of here.</p> <p>On 10/19/16 at 11:12 PM, the physician progress note stated he/she performed a psychiatric medication review of the resident's medications. The physician stated over the last month, he/she increased the Zyprexa due to the resident's behaviors and delusions. The physician progress note did not address the physical symptoms of a UTI.</p> <p>The 10/20/16 at 12:04 AM, progress note stated the resident did not make sense, and his/her urine started to smell again. The staff questioned if the resident needed to have a urinalysis (test for UTI) and the staff member reported the information to a nurse on shift. The medical record revealed the staff did not obtain a follow-up urinalysis and notify the physician of the resident change in condition, confusion, and foul smelling urine.</p>	F 315			

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F 315	<p>Continued From page 13</p> <p>The 10/24/16 at 1:31 PM, progress note stated the resident's urine still had a foul odor, and was tea colored.</p> <p>The 10/25/16 at 8:19 PM, progress note indicated staff reported the resident continued to have poor oral intake of food and fluids. The note stated the medication aide reported the resident continued to have dark, foul smelling urine.</p> <p>The 10/28/16 at 4:00 AM, progress note indicated the resident's temperature of 99.2 (F) Fahrenheit to the oncoming nurse. The medical record revealed the staff did not report the resident's temperature to the physician.</p> <p>The 11/1/16 at 4:52 PM, progress note stated an aide reported to the nurse the resident's urine smelled terrible, and the resident was confused. The note indicated the nurse recorded the resident's temperature as 99.5 F and no documentation the staff notified the physician of the resident's urine odor, confusion, and temperature.</p> <p>The 11/5/16 at 5:38 AM, progress note stated the resident had dark, foul smelling urine.</p> <p>Review of the medical record revealed no documentation the staff notified the physician regarding the resident's change of condition from 10/18/16 to 11/9/16, although the resident experienced symptoms of a UTI, and increased</p>	F 315			

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F 315	<p>Continued From page 14 confusion.</p> <p>The 11/9/16 at 2:45 AM, progress note indicated a standing order was written for a urinalysis due to the resident's dark amber urine, with a strong odor.</p> <p>The 11/9/16 at 5:35 AM, progress note stated the nurse catheterized the resident to obtain a sample of the dark amber, foul smelling urine for testing.</p> <p>The 11/10/16 at 10:51 AM urinalysis revealed the urine was yellow, cloudy, a trace amount of ketones (a substance made by the body when there is not enough urine in the blood), positive for nitrates (a test used to determine the type of bacteria in a urinary tract infection), 6-10 red blood cells, too many white blood cells to count, and packed bacteria.</p> <p>On 11/8/16 at 4:04 PM, observation revealed Nurse Aide D and Nurse Aide E entered the resident's room to check and change the resident for urinary incontinence. The aides removed the incontinence pad, which had a small green/brown area of bowel movement toward the back of the pad, and a large amount of urine soaked into the pad, observation as a brown to tan colored urine stain on the pad. Nurse Aide E cleaned the stool from the resident's coccyx, then with the same soiled glove on, applied barrier ointment to the open area on his/her scrotum. Both staff members removed his/her soiled gloves, and applied a clean pad.</p>	F 315			

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F 315	Continued From page 15 On 11/9/16 at 9:18 AM, observation revealed Nurse Aide F and Nurse Aide G assisted the resident to the commode. The pad revealed the resident was incontinent of bowel movement. Nurse Aide F attempted to clean the resident from the front with wet wipes, and tried to wipe downward, unable to visualize the skin area being wiped. He/she had difficulty getting the wipe in the groin area, and at one point wiped upward and circled the top of the groin with the wipe. Further observation revealed the nurse aides failed to offer the resident a drink of water during the cares, from the water pitcher which was located on the nightstand behind the head board of the resident's bed, out of his/her reach. On 11/8/16 at 4:15 PM, Nurse Aide D stated the resident's urine has smelled horrible for a long time, describing the urine as tan colored and dirty looking. On 11/9/16 at 9:58 AM, Nurse H stated the facility process was to utilize the physician's standing orders to obtain a urinalysis from the resident exhibiting symptoms of UTI. Nurse H stated the nurses would either fax or call the urinalysis results to the physician, who would start the resident on an antibiotic medication to treat the infection. Nurse H stated the facility would typically obtain a follow-up urinalysis after completion of the antibiotic, if the resident began exhibiting symptoms again. Nurse H stated he/she did not know why staff failed to inform the physician, and did not utilize the standing orders to collect another urinalysis sample for testing.	F 315			

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F 315	Continued From page 16 On 11/9/16 at 4:30 PM, Administrative Nurse A verified the nurse should perform an assessment when staff report symptoms, and based on the assessment, report any negative findings to the physician. Administrative Nurse A acknowledged the staff did not notify the physician of the resident's change in condition from 10/20/16 to 11/9/16. On 11/14/16 at 4:38 PM, Physician I stated staff should notify him/her in a timely manner, anytime a resident has a change in condition, including symptoms of a UTI. Physician I stated a follow-up urinalysis should be done after completion of an antibiotic if the resident continues to exhibit symptoms of the infection. The facility's November 2012, Change in a Resident's Condition or Status policy stated the facility shall promptly notify the resident, his or her attending physician, and representative, of changes in the resident's medical/mental condition and/or status. The charge nurse will notify the resident's attending physician or the on-call physician when there has been a significant change in the resident's physical/emotional/mental condition and a need to alter the resident's medical treatment significantly. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or status. The facility's October 2010, Perineal Care policy and procedure stated to assist the resident to a	F 315			

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F 315	<p>Continued From page 17</p> <p>lying position in bed and directed staff to adjust the linens, and:</p> <p>Wash the perineal area with a wet cloth starting with the urethra (the tube that extends from the urinary bladder to the exterior of the body) and working outward.</p> <p>Wash and rinse the urethral area using a circular motion.</p> <p>Continue to wash the perineal area including the penis, scrotum, and inner thighs. Do not reuse the same washcloth or water to clean the urethra.</p> <p>Wash the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks.</p> <p>The facility's staff failed to perform timely assessment, notify the physician of symptoms of a possible urinary tract infection, and provide appropriate perineal cleansing for Resident #1, who had a UTI, placing the resident at risk for further physical and mental decline, without medical attention.</p> <p>- Resident #2's medical record included diagnoses of parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, mask like faces, shuffling gait, muscle rigidity and weakness), benign prostatic hyperplasia (an enlarged prostate gland is a gland this is part of the male reproductive system), carcinoma of the prostate (cancer of the gland), major depressive disorder (major mood disorder), chronic pain</p>	F 315			

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F 315	<p>Continued From page 18</p> <p>(physical suffering or distress due to injury or illness, something that hurt's the body), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), ulcerative chronic pancolitis (inflammation of the entire large intestine), and diverticulosis of the large intestine (a condition in which small, bulging pouches develop in the digestive tract).</p> <p>The quarterly (MDS) Minimum Data Set assessment, dated 10/11/16, revealed the resident had moderately impaired cognition, required total assistance of 2 staff for bed mobility, transfer, dressing, toileting, and extensive assistance of 2 for eating and hygiene. The MDS further revealed the resident had poor balance, range of motion impairment on 1 lower extremity, frequent incontinence of urine and occasional incontinence of bowel.</p> <p>The urinary elimination (CAA) Care Area Assessment, dated 1/31/16, revealed the resident had urinary incontinence related to poor physical mobility, prostate cancer, and dementia (progressive mental disorder characterized by failing memory, confusion). The CAA further stated the resident had incontinence each morning when staff checked him/her at 6:00 AM and was at risk for increased incontinence.</p> <p>The urinary incontinence care plan, dated 10/26/16, revealed the resident had urge and functional (a person is aware of the urge to urinate, but for some physical or mental reason, the person can't get to the bathroom) incontinence, staff applied and changed briefs when soiled, and changed the resident clothing as needed following urinary incontinence episodes. The care plan directed staff to observe</p>	F 315			

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F 315	<p>Continued From page 19</p> <p>for signs and symptoms of urinary infection, such as a change in the color of the urine, cloudy, or blood tinged urine.</p> <p>The 10/15/16 at 8:09 PM, bladder evaluation revealed the resident had concentrated urine, wore briefs only at night, and wore pull-up briefs during the day. The evaluation stated the resident did not drink much on his/her own, had poor fluid intake, and directed staff to increase fluids at meals and to offer more fluids in the resident room.</p> <p>The 10/19/16 at 6:00 PM, 3 day voiding trial stated staff assisted the resident to the bathroom every 2-3 hours in addition to check and changing the resident. The trial revealed the resident had increased incontinence during the night when sleeping and staff checked and changed the resident.</p> <p>On 11/8/16 at 4:30 PM, Nurse Aide D and Nurse Aide E assisted the resident into the shower room to use the toilet and transferred the resident with a sit to stand lift. Nurse Aide D removed the resident incontinence pad, which had a small bowel movement, with urine saturating the pad, revealing a concentrated urine stain on the pad, about the size of a baseball radiating out. Nurse Aide E cleaned the resident coccyx from behind, then wiped the resident with a wet wipe downward in the groin area, folding the wipe over each time, wiped upward from the base of the perineum (the area from the anus to the scrotum in a male) upward to the top of the groin, and with a new area of the wipe cleaned around the penis with circular motion going over the same area more than once.</p>	F 315			

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F 315	<p>Continued From page 20</p> <p>On 11/8/16 at 4:37 PM, Nurse Aide E stated he/she had difficulty cleaning the resident from the back, so he/she attempted to clean the entire perineum from the front and verified this did not follow the procedure.</p> <p>On 11/9/16 at 4:30 PM Administrative Nurse A verified the staff should follow the procedure for peri-care, and should not clean from the rectum to the perineum or clean an area more than once with the same cloth.</p> <p>The facility's October 2010, Perineal Care policy and procedure stated to assist the resident to a lying position in bed and directed staff to adjust the linens, and to:</p> <p>Wash the perineal area with a wet cloth starting with the urethra (the tube that extends from the urinary bladder to the exterior of the body) and working outward.</p> <p>Wash and rinse the urethral area using a circular motion.</p> <p>Continue to wash the perineal area including the penis, scrotum, and inner thighs. Do not reuse the same washcloth or water to clean the urethra</p> <p>Wash the rectal area thoroughly, including the area under, the scrotum, anus, and the buttocks.</p> <p>The facility's staff failed to provide appropriate perineal cleansing for Resident #2, placing the resident at an increased risk for urinary tract infection.</p>	F 315			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	Continued From page 21 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 infection.	F 441			

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F 441	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 44 residents. The sample included 3 residents. Based on observation, record review, and interview the facility failed to provide appropriate perineal care for Resident #1 and Resident #2 and did not remove soiled gloves prior applying barrier ointment to a wound.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - On 11/8/16 at 4:04 PM, observation revealed Nurse Aide D and Nurse Aide E entered the Resident #1's room to check and change the resident for urinary incontinence. The aides removed the incontinence pad, which had a small green/brown area of bowel movement toward the back of the pad, and a large amount of urine soaked into the pad, observation as a brown to tan colored urine stain on the pad. Nurse Aide E cleaned the stool from the resident's coccyx, then with the same soiled glove on, applied barrier ointment to the open area on his/her scrotum. Both staff members removed his/her soiled gloves, and applied a clean pad. <p>On 11/9/16 at 9:18 AM, observation revealed Nurse Aide F and Nurse Aide G assisted the resident to the commode. The pad revealed the resident was incontinent of bowel movement. Nurse Aide F attempted to clean the resident from the front with wet wipes, and tried to wipe downward, unable to visualize the skin area being wiped. He/she had difficulty getting the wipe in the groin area, and at one point wiped upward and circled the top of the groin with the wipe. Further observation revealed the nurse aides failed to offer the resident a drink of water during the</p>	F 441			

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F 441	<p>Continued From page 23</p> <p>cares, from the water pitcher which was located on the nightstand behind the head board of the resident's bed, out of his/her reach.</p> <p>On 11/8/16 at 4:30 PM, Nurse Aide D and Nurse Aide E assisted Resident #2 into the shower room to use the toilet and transferred the resident with a sit to stand lift. Nurse Aide D applied gloves and removed the resident's incontinence pad, which had a small bowel movement, with urine saturating the pad, revealing a concentrated urine stain on the pad, about the size of a baseball radiating out. Nurse Aide E, with gloves on, cleaned the resident's coccyx from behind, then wiped the resident with a wet wipe downward in the groin area, folding the wipe over each time, wiped upward from the base of the perineum (the area from the anus to the scrotum in a male) upward to the top of the groin, and with a new area of the wipe cleaned around the penis with circular motion going over the same area more than once. Nurse Aide E, with the same soiled gloves, applied barrier cream to the resident's perineum areas, including the open wound on the resident's scrotum.</p> <p>On 11/8/16 at 4:37 PM, Nurse Aide E stated he/she had difficulty cleaning the resident from the back, so he/she attempted to clean the entire perineum from the front and verified this did not follow the procedure. Nurse Aide E verified he/she did not remove the soiled glove used to clean the resident coccyx, and applied barrier cream, with the same soiled glove, to an open wound on the resident's scrotum.</p> <p>On 11/9/16 at 9:58 AM, Nurse H stated the nurse aides provide peri-care after each incontinence</p>	F 441			

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F 441	<p>Continued From page 24</p> <p>episode. Nurse H stated he/she tries to observe staff performing cares, since he/she is often the second person helping the aides to provide the care.</p> <p>On 11/9/16 at 4:30 PM Administrative Nurse A verified the staff should follow the procedure for peri-care and should not clean from the rectum to the perineum or clean an area more than once with the same cloth. Administrative Nurse A stated the residents' care plans included monitoring for signs of infection, along with check and change programs, and explained staff receive in-service training on hand washing and glove use.</p> <p>The facility's October 2010, Perineal Care policy and procedure stated to assist the resident to a lying position in bed and directed staff to adjust the linens, and to:</p> <p>Wash the perineal area with a wet cloth starting with the urethra (the tube that extends from the urinary bladder to the exterior of the body) and working outward.</p> <p>Wash and rinse the urethral area using a circular motion.</p> <p>Continue to wash the perineal area including the penis, scrotum, and inner thighs. Do not reuse the same washcloth or water to clean the urethra</p> <p>Wash the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks.</p> <p>The facility failed to provide a sanitary environment to help prevent the development and</p>	F 441			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175295	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/16/2016
NAME OF PROVIDER OR SUPPLIER SMITH CENTER OPERATOR, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 117 W 1ST STREET #369 SMITH CENTER, KS 66967		
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F 441	Continued From page 25 transmission of disease and infection, by failing to follow the policy and procedure for perineal care and ensure staff changed gloves at the appropriate time, placing Resident #1 and Resident #2 at an increased risk for urinary tract infection.	F 441		