STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00164693 and KS00161683. This 2567 was electronically sent to the facility on 08/10/22.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 657	Continued From page 1	F 657		

by:
The facility reported a census of 72 residents with 20 residents sampled. Based on observation, interview and record review, the facility failed to review and revise the care plan for this dependent Resident (R)17, regarding toileting.

Findings included:

- Review of the Resident (R)17's electronic medical record (EMR), electronically signed orders under the "Orders" tab, dated 06/02/22, documented the resident had diagnoses which included: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and overactive bladder (a bladder control problem which leads to a sudden urge to urinate).

The modification of the significant change "Minimum Data Set" (MDS), dated 04/15/22, documented the staff assessment of the resident's cognition revealed severely impaired cognition. She had no rejection of care. She required extensive assistance of one staff for toilet use and was frequently incontinent of bladder.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 04/15/22, documented the resident had a diagnosis of overactive bladder which contributed to her need for assistance with toileting.

The quarterly "MDS," dated 05/16/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of two, indicating severe cognitive impairment. She had no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 657	Continued From page 2	F 657		

rejection of care. She required extensive assistance of one for toileting and was frequently incontinent of bladder.

The care plan for bowel and bladder, revised 04/23/22, instructed staff to provide peri-care (the cleansing of the genitals) with each incontinent episode. The care plan lacked staff instructions on a toileting plan for this resident.

Review of the resident's EMR, under the "Tasks" tab, from 07/04/22 through 08/01/22, documented the resident required limited to total assistance of one to two staff for toileting and had multiple episodes of bladder continence, as well as bladder incontinence.

Review of the resident's EMR, under the "Misc" (miscellaneous) tab, revealed a "Bladder Retraining Record", dated 10/11/22 through 10/13/22, which documented the resident had multiple episodes of bladder continence and incontinence.

On 08/03/22 at 11:15 AM, the resident sat in the commons area watching TV, where she remained until 11:59 AM, when Certified Nurse Aide (CNA) NN propelled the resident to the dining room table for lunch. There was no offer to toilet before the meal. At 12:41 PM, CNA M propelled the resident from the dining table back into the commons area where the resident remained until 01:00 PM, when Certified Medication Aide (CMA) S propelled the resident to her room to toilet. The resident's brief observed to be saturated with urine. CMA S provided peri-care and failed to change her gloves after removing the wet brief, providing peri-care and putting on a clean brief.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 657	Continued From page 3	F 657		

On 08/03/22 at 11:24 AM, CNA M stated staff needed to toilet the resident every two hours. If the resident became restless, then staff knew she needed to be toileted. The resident was able to be continent of urine if staff got her to the bathroom in time. The resident did not have a toileting plan other than for staff to toilet her every two hours.

On 08/04/22 at 10:10 AM, CNA N stated staff tried to toilet the resident every two hours. The resident was able to be continent of urine if staff got her to the bathroom in time.

On 08/04/22 at 10:29 AM, Licensed Nurse (LN) G stated staff would complete a 72 -hour voiding diary on residents who were a new admission, re-admissions or who had a change in condition. The voiding diaries would help staff develop an individualized toileting plan for residents. LN G stated the staff toilet her every two hours, but the resident had usually been incontinent by that time. The resident did not have a toileting plan, but she could be continent of bladder at times. All nurses were able to review and revise the care plans from their computers.

On 08/05/22 at 09:03 AM, Administrative Nurse D stated all residents should have a toileting program individualized to their needs. Staff need to help the residents maintain their continence. The voiding diary should be used to develop an appropriate toileting program for each resident. Nurses should update care plans with any changes in the resident's treatments or condition.

The facility policy for "Person-Centered Care Planning", revised 09/09/21, included: Any changes in a resident's condition always requires

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 657	Continued From page 4 changes to be made in the plan of care either by change in individual approaches or by the addition of new problems to the plan of care. The facility failed to review and revise the care plan for this incontinent dependent resident to include a toileting plan.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents with 20 residents sampled, including two residents reviewed for activities of daily living (ADL)s. Based on interview, observation, and record review, the facility failed to provide two dependent Residents (R)12 and R 42 appropriate assistance with ADLs, regarding R 12 for dirty clothing and R 42 regarding a dirty lap blanket. Findings included: - Review of Resident (R)12's electronic medical record (EMR), under the "Med Diag" (medical diagnosis) tab, revealed a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The significant change "Minimum Data Set" (MDS), dated 11/24/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of 0, indicating severe cognitive	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 677	Continued From page 5	F 677		

impairment. The resident required extensive assistance of two staff for dressing. He had impairment in range of motion (ROM) on both sides of upper and lower extremities.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA), dated 11/24/21, did not trigger.

The "Cognitive Loss/Dementia CAA", dated 11/24/21, documented the resident had an active diagnosis of Alzheimer's disease.

The quarterly "MDS," dated 05/08/22, documented the resident had a BIMS score of 0, indicating severe cognitive impairment. He required total assistance of two staff for dressing and had impairment in ROM on both sides of upper and lower extremities.

The care plan for ADLs, revised 07/23/22, instructed staff the resident required one staff assistance for dressing.

Review of the resident's EMR under the "Tasks" tab, from 07/06/22 through 08/03/22, revealed the resident required extensive to total assistance of one to two staff for dressing.

On 08/03/22 at 09:51 AM, Certified Medication Aide (CMA) R and Certified Nurse Aide (CNA) Q transferred the resident from his wheelchair to the recliner with the use of a full mechanical body lift. The resident's navy blue t-shirt had food debris around the collar. Staff did not offer to change the resident's shirt or attempt to clean him.

On 08/03/22 at 10:10 AM, Licensed Nurse (LN) H cleaned the resident's eyes with a soft cloth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 677	Continued From page 6	F 677		

Staff made no attempt to clean the resident's dirty t-shirt and no offer to change his soiled shirt.

On 08/03/22 at 02:06 PM, LN H and CMA R propelled the resident into his room to provide peri care. Staff transferred the resident from his geri-chair (a reclined moveable chair) to his bed with the use of the full mechanical lift. The staff provided cares and prepared to transfer the resident back into his geri-chair to return to the commons area. Upon request, staff changed his dirty soiled shirt before taking him back out to the commons area.

On 08/03/22 at 09:51 AM, CNA Q confirmed the resident had on a dirty shirt.

On 08/03/22 at 02:21 PM, CNA R stated staff should change residents' clothes if they are dirty.

On 08/03/22 at 02:21 PM, Licensed Nurse (LN) H stated she had seen the front of the resident's shirt had something on it, but thought it was just discoloration. LN H stated staff should change resident's clothes when they become dirty.

On 08/05/22 at 09:03 AM, Administrative Nurse D stated staff should be ensuring all residents are wearing clean clothing.

The facility policy for "Resident Rights", effective November 24, 2021, included: All residents have the right to be treated with consideration, respect and dignity.

The facility failed to ensure this dependent resident had on clean clothing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 677	Continued From page 7	F 677		

- Review of Resident (R)42's electronic medical record (EMR), under the "Med Diag" (medical diagnosis) tab, included a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness).

The significant change "Minimum Data Set" (MDS), dated 04/01/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. He required extensive assistance of two staff for dressing and personal hygiene.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment" (CAA), dated 04/01/22, did not trigger.

The quarterly "MDS," dated 06/24/22, documented the staff assessment for cognition revealed severe cognitive impairment. The resident required total assistance of two staff for dressing.

The ADL care plan, revised 07/02/22, instructed staff the resident required one staff assistance for dressing.

Review of the resident's EMR under the "Tasks tab", from 07/06/22 through 08/01/22, revealed the resident required total dependance of one staff for personal hygiene and dressing.

On 08/03/22 at 07:51 AM, Certified Nurse Aide (CNA) Q propelled the resident to the nurses' desk. The resident's dark blue lap blanket had a large area of dried food on the end of the blanket.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 677	Continued From page 8	F 677		

On 08/03/22 at 02:28 PM, the resident continued to have the large area of dried food on his blanket.

On 08/04/22 at 09:01 AM, the resident sat in his geri-chair (a reclined moveable chair) in the commons area covered with the dark blue blanket which contained two large areas of dried food.

On 08/03/22 at 09:25 AM, Certified Medication Aide (CMA) R stated staff should ensure resident's lap blankets are clean. If they become soiled with food or something, they should be changed, and the dirty blanket taken to the laundry.

On 08/04/22 at 09:58 AM, Certified Nurse Aide (CNA) O stated staff need to be sure the residents have clean blankets. CNA O stated the resident's blanket had two large areas of food which had dried.

On 08/04/22 at 09:54 AM, Licensed Nurse (LN) I stated staff should ensure the resident's blankets are clean. The staff are responsible for ensuring the residents' have clean clothing and blankets.

On 08/05/22 at 09:03 AM, Administrative Nurse D stated it was the expectation for staff to ensure residents have clean lap blankets.

The facility policy for "Resident Rights", effective November 24, 2021, included: All residents have the right to be treated with consideration, respect and dignity.

The facility failed to ensure this dependent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 677	Continued From page 9 resident had a clean lap blanket.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents with 20 residents sampled, including two residents reviewed for Pressure Ulcers (PU). Based on interviews, record review, and observations, the facility failed to promote the prevention of pressure ulcer development for one Resident (R)42, at risk for the development of pressure ulcers. Findings included: - Review of Resident (R)42's electronic medical record (EMR), under the "Med Diag" (medical diagnosis) tab, revealed the resident had a diagnosis of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 686	Continued From page 10	F 686		

weakness).

The significant change "Minimum Data Set" (MDS), dated 04/01/22, documented the resident had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. He required extensive assistance of two staff for bed mobility and used a wheelchair. The resident was at risk for the development of pressure ulcers (PU) (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) and had no unhealed PUs at the time of the assessment. He had a pressure relieving device for his bed and his chair.

The "Pressure Ulcer Care Area Assessment" (CAA), dated 04/01/22, documented the resident had generalized muscle weakness and required staff assistance with transfers and activities of daily living (ADLs).

The quarterly "MDS," dated 06/24/22, revealed the staff assessment for cognition revealed severe cognitive impairment. He required total assistance of two staff for bed mobility and transfers. He was at risk for the development of PUs with an unhealed PU at the time of the assessment. The resident had one stage II PU (partial-thickness skin loss into but no deeper than the dermis), which was not present on admission. He had a pressure reducing device for his chair and bed, was on a turning and repositioning program and a nutrition or hydration interventions to manage skin problems. He received PU care.

The care plan for skin, revised 07/02/22,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 686	Continued From page 11	F 686		

instructed staff the resident had expected skin breakdown due to his disease process and his admission to hospice. Staff were to ensure the resident had a pressure relieving cushion in his wheelchair and a pressure relieving mattress.

Review of the resident's EMR, under the "Assessment" tab, revealed Braden assessments (an assessment to predict the risk of the development of PUs), dated 06/23/22 and 04/01/22, which placed the resident at a moderate risk for the development of PUs.

Review of the resident's EMR, under the "Orders" tab, revealed an order to cleanse the open area to the resident's left coccyx with normal saline (NS), apply skin prep (skin protection), and apply a Mepilex dressing (an absorbent foam dressing), every three days until resolved, ordered 07/29/22.

Review of the resident's EMR, under the "Assessments" tab, included "Wound Assessment Forms", which documented the following:

On 07/21/22, the resident developed a stage II PU to his coccyx (left buttocks area), which measured 0.5 length (L) by 0.3 width (W) by 0.1 depth (D) centimeters (cm). The wound had well defined edges and no drainage. The treatment was to cleanse the area with NS, apply skin prep and apply a hydrocolloid dressing (a dressing with gel-like properties to absorb excretions from the wound and protect the wound debris and potentially infection causing bacteria), ordered 07/21/22.

On 07/28/22, the resident's stage II PU measured 0.5 L by 0.3 W by 0.1 D cms. The wound bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 686	Continued From page 12	F 686		

was 100% red/pink and there was no drainage from the wound. The treatment was to cleanse the open area to the left coccyx with NS, apply skin prep and cover with a Mepilex dressing, ordered 07/28/22.

On 08/03/22, the resident's stage II PU measured 0.1 L by 0.1 W by 0.1 D cms. The wound had bright red granulation (new vascular tissue in granular form on an ulcer or the healing surface of a wound) tissue and no drainage. There was no change in the treatment of the PU.

On 08/03/22 at 07:51 AM, the resident sat in his geri-chair (a reclining wheelchair) in front of the nurse's station. The wheelchair had a pressure relieving cushion in place. At 08:00 AM, staff propelled the resident into the commons area and placed him in front of the TV, where he remained until 08:50 AM. At 08:50 AM, Licensed Nurse (LN) H propelled the resident from the commons area to the dining table for breakfast. Certified Medication Aide (CMA) R assisted the resident with his meal. At 09:45 AM, CMA R removed the resident from the dining table and propelled him to the commons area. At 10:25 AM, CMA R and Certified Nurse Aide (CNA) P transfer the resident from his geri-chair to a recliner with the use of a full body mechanical lift. The staff failed to move the pressure relieving cushion from the resident's geri-chair to the recliner and sat the resident down directly onto the recliner without the use of a pressure relieving device.

On 08/03/22 at 02:28 PM, CNA Q and CNA P, transferred the resident from his geri-chair to the recliner with the use of the full body mechanical lift. The staff failed to move the pressure relieving cushion from the resident's geri-chair to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 686	Continued From page 13	F 686		

the recliner and sat the resident down directly onto the recliner without the use of a pressure relieving device.

On 08/04/22 at 06:49 AM, LN HH and CNA OO, entered the resident's room to do a dressing change to the open area on his left buttocks area. Staff rolled the resident to his left side and removed the dressing, dated 08/03/22. The open area measured 0.1 L by 0.1 W by 0.1 D. The wound bed was pink and had no drainage. LN HH cleansed the wound with NS and covered the open area with a Mepilex dressing, dated and initialed.

On 08/03/22 at 09:25 AM, CMA R stated staff should turn and reposition the resident every two hours due to his pressure ulcers. CMA R stated the resident had a pressure relieving cushion in his wheelchair, but staff did not put the cushion in the recliner when they transferred him because the recliner was foam and he did not need a cushion in the recliner.

On 08/04/22 at 09:58 AM, CNA O stated the resident's cushion was to be kept in his wheelchair. Staff did not put the cushion into the resident's recliner because it needed to be kept in the wheelchair.

On 08/02/22 at 08:35 AM, LN H stated the PU to the resident's left buttocks developed in house.

On 08/03/22 at 02:33 PM, Administrative Nurse E stated the resident did not have a pressure relieving cushion in his recliner because he was not care planned to have one. The recliner seat was not a pressure relieving surface but was foam, which was sufficient. Administrative Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 686	Continued From page 14 E confirmed the PU to the resident's left buttocks developed in house. On 08/04/22 at 09:54 AM, LN I stated the resident acquired the stage II PU to his left buttocks at the facility. The resident had a pressure relieving cushion in his wheelchair, but staff did not transfer the cushion to the recliner when they put the resident in the recliner. On 08/05/22 at 09:03 AM, Administrative Nurse D stated the resident required a cushion in his wheelchair and the recliner due to being at risk for the development of PUs. The facility policy for "Skin Injury Protocol", effective October 13, 2020, included: Upon admission, each resident will be evaluated for risk of development of pressure injuries and appropriate interventions for prevention. Interventions for prevention will be evaluated for appropriateness. The facility failed to promote the prevention of pressure ulcer development for this dependent resident at risk for PUs.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 690	Continued From page 15	F 690		

incontinence, based on the resident's comprehensive assessment, the facility must ensure that-
(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents with 20 selected for review, which included one resident reviewed for urinary incontinence and one resident reviewed for urinary catheter. Based on observation, interview and record review, the facility failed to ensure one resident (R)38 received proper catheter maintenance, and one resident (R) 17 received timely toileting opportunities.

Findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 690	Continued From page 16	F 690		

- Review of Resident (R)38's "Physician Order Sheet," dated 06/17/22, revealed diagnoses included bilateral (both) lower extremity amputation, pneumonia (inflammation of the lungs,) and ischemic heart disease (lack of oxygenated blood to the heart).

The "Significant Change Minimum Data Set" (MDS), dated 06/20/22 assessed the resident with normal cognitive function, and required extensive assistance of two staff for bed mobility, transfer, dressing, toilet use, and personal hygiene. The resident had no impairment in functional range of motion of the upper and lower extremities. The resident had a urinary catheter.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 06/20/22, assessed the resident had urinary incontinence due to neuromuscular dysfunction of the bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and chronic (persisting for a long period, often for the remainder of the person's life) kidney disease.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential CAA," dated 06/20/22, assessed the resident required increased assistance due to the absence of both legs and increased weakness due to end stage renal disease and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).

The "Care Plan," reviewed 04/16/21, instructed staff the resident had neuromuscular dysfunction of the bladder (bladder did not empty completely and had increased urge to urinate). The "Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 690	Continued From page 17	F 690		

Plan" lacked interventions for the use of a urinary catheter.

Observation on 08/02/22 at 01:08 PM, revealed the resident in droplet precautions due to pneumonia. The resident responded slowly to questions. The resident had a urinary catheter.

Observation, on 08/04/22 at 08:02 AM, revealed the resident positioned in bed with red drainage on the bed linen around his groin area and the urinary catheter with the bulb still inflated on the floor beside his bed.

Interview on 08/04/22 at 08:02 AM, Licensed Nursing Staff (LN) GG confirmed the resident pulled his catheter out. Since the resident received hospice services, she would notify the physician and hospice for further orders.

Observation, on 08/05/22 at 08:02 AM, revealed the urine collection bag and approximately six inches of tubing lay directly on the floor. LN L stated hospice inserted the catheter on 08/04/22, and confirmed the catheter lacked an anchoring device and told Certified Nursing Staff (CNA) MM to apply one.

Interview, on 08/05/22 at 08:08 AM, with CNA MM, revealed the previous shift reported the resident attempted to pull on his catheter during the night.

Interview on 08/05/22 at 11:01 AM, with Administrative Nurse DD, revealed she would expect staff to ensure the catheter had an anchoring device and keep the urine collection bag off the floor and in a dignity bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 690	Continued From page 18	F 690		

The facility policy "Bladder Catheter Procedures," dated 07/07/22, instructed staff to secure the catheter to the resident's leg, place the urine bag and tubing in a dignity bag to prevent embarrassment and avoid letting the drainage bag and tubing touch the floor.

The facility failed to ensure staff secured this resident's catheter with an anchoring device, failed to secure the urine collection from touching the floor and failed to apply a dignity bag.

- Review of the Resident (R)17's electronic medical record (EMR), electronically signed orders under the "Orders" tab, dated 06/02/22, documented the resident had diagnoses which included: Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and overactive bladder (a bladder control problem which leads to a sudden urge to urinate).

The modification of the significant change "Minimum Data Set" (MDS), dated 04/15/22, documented the staff assessment of the resident's cognition revealed severely impaired cognition. She had no rejection of care. She required extensive assistance of one staff for toilet use and was frequently incontinent of bladder.

The "Urinary Incontinence and Indwelling Catheter Care Area Assessment" (CAA), dated 04/15/22, documented the resident had a diagnosis of overactive bladder which contributed to her need for assistance with toileting.

The quarterly "MDS," dated 05/16/22, documented the resident had a Brief Interview for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 690	Continued From page 19	F 690		

Mental Status (BIMS) score of two, indicating severe cognitive impairment. She had no rejection of care. She required extensive assistance of one for toileting and was frequently incontinent of bladder.

The care plan for bowel and bladder, revised 04/23/22, instructed staff to provide peri-care (the cleansing of the genitals) with each incontinent episode.

Review of the resident's EMR, under the "Tasks" tab, from 07/04/22 through 08/01/22, documented the resident required limited to total assistance of one to two staff for toileting and had multiple episodes of bladder continence, as well as bladder incontinence.

Review of the resident's EMR, under the "Misc" (miscellaneous) tab, revealed a "Bladder Retraining Record", dated 10/11/22 through 10/13/22, which documented the resident had multiple episodes of bladder continence and incontinence.

On 08/03/22 at 11:15 AM, the resident sat in the commons area watching TV, where she remained until 11:59 AM, when Certified Nurse Aide (CNA) NN propelled the resident to the dining room table for lunch. There was no offer to toilet before the meal. At 12:41 PM, CNA M propelled the resident from the dining table back into the commons area where the resident remained until 01:00 PM, when Certified Medication Aide (CMA) S propelled the resident to her room to toilet. The resident's brief observed to be saturated with urine. CMA S provided peri-care and failed to change her gloves after removing the wet brief, providing peri-care and putting on a clean brief.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 690	Continued From page 20	F 690		

On 08/03/22 at 11:24 AM, CNA M stated staff needed to toilet the resident every two hours. If the resident became restless, then staff knew she needed to be toileted. The resident was able to be continent of urine if staff got her to the bathroom in time. The resident did not have a toileting plan other than for staff to toilet her every two hours. CNA M stated she should have changed her gloves after she removed the resident's wet brief.

On 08/04/22 at 10:10 AM, CNA N stated staff tried to toilet the resident every two hours. The resident was able to be continent of urine if staff got her to the bathroom in time.

On 08/04/22 at 10:29 AM, Licensed Nurse (LN) G stated staff would complete a 72 -hour voiding diary on residents who were a new admission, re-admissions or who had a change in condition. The voiding diaries would help staff develop an individualized toileting plan for residents. LN G stated the staff toilet her every two hours, but the resident had usually been incontinent by that time. The resident did not have a toileting plan, but she could be continent of bladder at times. Staff should change their gloves while performing peri-care after removing the soiled brief and putting on a clean brief.

On 08/05/22 at 09:03 AM, Administrative Nurse D stated all residents should have a toileting program individualized to their needs. Staff need to help the residents maintain their continence. The voiding diary should be used to develop an appropriate toileting program for each resident. Staff should change their gloves while performing peri-care after removing the soiled brief and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 690	Continued From page 21 putting on a clean brief. The facility policy for "Bladder Management", effective 01/01/2000, included: Staff should observe and record the resident's voiding pattern and revise the toileting schedule to meet resident's needs. The Unit Coordinator will develop a toileting schedule based on the resident's voiding pattern identified by the 3-day voiding diary. The facility policy for "Perineal Care Procedure", effective April 2, 2019, included: The purpose of the policy was to ensure staff's knowledge to cleanse the perineum to prevent infection and odor. The facility failed to develop an individualized toileting program for this dependent resident.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility reported a census of 72 residents. The sample of 20 residents included six residents sampled for respiratory care. Based on observation, interview, and record review, the facility failed to provide appropriate respiratory	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 695	Continued From page 22	F 695		

care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person-centered care plan for three Residents. (R)31 related to storage and labeling/dating of oxygen tubing and maintaining distilled water in the humidifier bottle of the oxygen concentrator; R 38 related to labeling/dating oxygen tubing; and R 54 related to storage of the nebulizer kit.

Findings included:

- Review of Resident's (R)31's "Physician Orders," dated 07/18/22, revealed diagnoses which included, chronic obstructive pulmonary disease (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and dependence on supplemental oxygen.

The "Admission Minimum Data Set" (MDS) dated 03/15/22, documented the "Brief Interview for Mental Status" (BIMS) score of 12 , which indicated moderate cognitive impairment. He required extensive assistance with transfers, and he used oxygen.

The quarter MDS, dated 6/10/22, documented no changes from the above.

The "Care Area Assessment" (CAA), dated 03/17/22, documentation lacked address of the resident's oxygen use.

The "Care Plan," (CP), dated 06/21/22, directed staff the resident required oxygen therapy. Staff were to provide the resident supplemental oxygen as needed. Provide care and maintenance to oxygen devices per facility protocol. Replace the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 695	Continued From page 23	F 695		

cannula and concentrator per the facility policy. All tubing should be kept in an infection control bag when not in use to prevent cross contamination. Label/date the oxygen tubing and the humidifier bottle with the date of change/replacement.

The "Physician Orders," dated 06/06/2022, included Oxygen via nasal cannula at three liters per minute. All tubing to be kept in infection control bag and assess bag for replacement. Replace the O2 tubing, label with date exchanged.
On 08/02/22 at 09:49 AM, the oxygen concentrator lacked water in the undated humidifier bottle. The oxygen tubing laid directly on the floor and lacked a bag to store the undated tubing when not in use.

On 08/02/22 at 09:49 AM, Certified Nurse Aide (CNA) P, confirmed the above findings. She stated the third shift nurse was responsible for changing out the oxygen equipment weekly and all nursing staff should be checking for the water level in the humidifier bottle as well as the proper storage of the tubing when not in use. CNA P stated she would notify the nurse when the oxygen concentrator's humidifier bottle needed water and the resident needed a bag for the oxygen tubing storage.

On 08/02/22 at 10:05 AM, Licensed Nurse (LN) H, entered the resident's room and verified the above findings. She stated the oxygen tubing and humidifier bottle should be labelled with the date the staff replaced it. The humidifier bottle should have distilled water to prevent drying out the resident's airway and there should be a bag available to store the oxygen tubing and cannula

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 695	Continued From page 24	F 695		

when not in use to prevent cross contamination.

On 08/04/22 at 11:06 AM, the resident's undated oxygen tubing and cannula was wrapped around the resident's wheelchair (W/C) handle. The w/c lacked a bag to store the oxygen tubing and cannula when not in use to prevent cross contamination.

On 08/04/22 at 11:10 AM, Administrative Nurse DD confirmed the resident's undated oxygen tubing and cannula were wrapped around the w/c handle and not stored in a bag to prevent cross contamination. She stated the expectation was that staff should label/date the oxygen tubing and the humidifier bottles and should be changed weekly. The humidifier bottles should have distilled water in the bottle to prevent drying of the resident's airway, and the oxygen tubing and cannula should be stored in a bag when not in use to prevent cross contamination.

The facility policy for "Oxygen Administration Safety," dated 08/27/2020, documentation included staff to store all cannulas, masks and tubing in a designated storage bag when not in use, nasal cannulas, masks, and tubing would be changed weekly. The storage bag would be changed and dated weekly or more often if needed. Fill the humidifier bottles to the fill line as indicated, using distilled water. Replace humidifier bottles once a week. Humidifier should be labeled with date and time changed.

The facility failed to provide appropriate respiratory care in maintaining respiratory equipment to prevent the spread of infection, consistent with standards of practice and person-centered care plan for this resident, who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 695	Continued From page 25	F 695		

required oxygen.
- Review of Resident (R)54's "Physician Order Sheet," dated 07/18/22, revealed diagnoses included chronic respiratory failure, COPD (chronic obstructive lung disease a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and pneumonitis (inflammation of the lung tissue).

The "Significant Change Minimum Data Set" (MDS), dated 04/08/22, assessed the resident with normal cognitive function, and required extensive assistance of one person for transfer, dressing, toilet use, and personal hygiene. The resident had no functional impairment in range of motion in the upper and lower extremities.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment" (CAA) dated 04/08/22, assessed the resident required increased assistance with ADL's.

The "Care Plan", reviewed 07/16/22, instructed staff the resident had COPD and used supplemental oxygen.

A "Physician's Order," dated 07/20/22, instructed staff to administer Ipratropium-Albuterol (medications that dilates the airways) solution 0/5-2.5 mg (milligrams)/3 ml (millimeters,) inhale, four times a day, for pneumonitis.

Observation, on 08/02/22 at 10:30 AM, revealed the resident in contact isolation for exposure to COVID. The resident's nebulizer equipment laid directly on a table with packages of food, papers, neck pillow and generalized clutter. A gallon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 695	Continued From page 26	F 695		

container of distilled water was positioned directly on the floor in the resident's room. The resident wore oxygen which was connected to an oxygen concentrator with a humidifier (a device filled with water to humidify the oxygen). The oxygen concentrator contained adhesive residue and grime.

Observation, on 08/05/22 at 10:45AM, revealed the resident's nasal cannula was draped over the oxygen concentrator and part of the tubing laid directly on the floor, with the oxygen concentrator running and the resident was absent from the room.

Interview, on 08/05/22 at 11:50 AM, with the resident, revealed staff used the distilled water to fill his humidifier on the oxygen concentrator.

Observation, on 08/05/22 at 12:00 PM, with Administrative Nurse DD, confirmed staff should store the nebulizer equipment in a sanitary manner and the keep the oxygen concentrator clean, with the tubing in the sanitary bag attached to the concentrator. Staff should keep the distilled water off the floor.

The facility policy "Nebulizer Treatment," reviewed 04/28/20, instructed staff to remove the tubing, wash the components and air dry on a clean cloth and then store the parts in a sealable plastic bag or designated container.

The facility policy "Oxygen Administration Safety," reviewed 08/27/20, instructed staff to store all cannulas, masks and tubing in a designated storage bag when not in use. Staff instructed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 695	Continued From page 27	F 695		

turn off the oxygen if not in use.

The facility failed to ensure staff provided oxygen in a sanitary manner and failed to store this resident's nebulizer equipment in a sanitary manner to prevent the spread of infection.

- Review of Resident (R)38's "Physician Order Sheet," dated 06/17/22, revealed diagnoses included pneumonia (inflammation of the lungs,) and ischemic heart disease (lack of oxygenated blood to the heart).

The "Significant Change Minimum Data Set" (MDS), dated 06/20/22 assessed the resident with normal cognitive function . The resident required oxygen therapy.

The "ADL (Activity of Daily Living) Functional/Rehabilitation Potential CAA," dated 06/20/22, assessed the resident required increased assistance due to the absence of both legs and increased weakness due to end stage renal disease and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).

The "Care Plan," reviewed 07/30/33, instructed staff the resident received hospice services and supplied the oxygen supplies and concentrator.

A "Physician's Order," dated 07/30/22, instructed staff to administer oxygen as resident's norm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 695	Continued From page 28 Observation on 08/02/22 at 01:08 PM, revealed the resident in droplet precautions due to pneumonia. The resident responded slowly to questions. The resident received oxygen through a nasal canula. The oxygen tubing/humidifier was not dated. The oxygen tubing/humidifier remained undated through 08/04/22. Observation, on 08/04/22 at 08:02 AM, revealed the resident positioned in bed. The resident's oxygen tubing was directly on the floor beside his bed. Interview, on 08/05/22 at 10:30 AM, with Administrative Nurse DD, revealed she expected staff to ensure oxygen tubing was changed weekly and dated accordingly. The facility policy "Oxygen Administration Safety," reviewed 08/27/20, instructed staff to change the oxygen tubing once a week. The humidifier bottle should be replaced once a week and labeled with date and time changed. The facility failed to date the oxygen tubing and humidifier to ensure staff changed the tubing/humidifier once a week to prevent the spread of infection. In addition, the facility failed to provide appropriate oxygen tubing storage to prevent the spread of infection, for this resident who required oxygen.	F 695		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 880	Continued From page 29	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 880	Continued From page 30	F 880		

least restrictive possible for the resident under the circumstances.
(v) The circumstances under which 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; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 72 residents. Based on observation, interview and record review, the facility failed to ensure staff disinfected the facility's multi resident use glucometer and failed to ensure staff administered an inhaler, insulin and eye drops to a resident in isolation were sanitized in an effective manner before returning them to the medication cart to prevent cross contamination.

Findings included:

- Observation, on 08/03/22 at 11:19 AM, revealed Licensed Nurse (LN) L, obtained resident (R)18's blood glucose with a multi-use glucometer (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 880	Continued From page 31	F 880		

glucometer that staff used for multiple residents.) Upon completion, LN L proceeded to use an alcohol prep pad to wipe the surface of the glucometer. LN L stated there were antibacterial wipes somewhere, but she thought the alcohol wipe was sufficient to sanitize the glucometer. LN L stated she had four more residents to obtain blood glucose levels from.

Interview, on 08/03/22 at 11:30 AM, with Administrative Nurse F, revealed she thought the alcohol wipe or antibacterial wipes available for use were to sanitize the glucometer.

Interview, on 08/03/22 at 11:45AM, with Administrative Staff A, revealed staff should follow the manufacturer's recommendations to clean and disinfect the glucometer. Administrative Staff A confirmed the manufacturer's recommendations indicated isopropyl alcohol or a cloth damped with soapy water were acceptable to clean the glucometer, but to disinfect the glucometer a solution of bleach or an approved list of wipes was needed for sanitization. Administrative Staff A stated eight residents on this unit utilized the glucometer.

The glucometer manufacturer's recommendations included using a commercially available EPA (environmental protective agency) registered disinfectant detergent of germicide wipe. The manufacturer's recommendations indicated to clean the glucometer with isopropyl alcohol 70-80%, and to disinfect the meter with a dilution of 1:10 bleach solution or a germicide wipe.

The facility failed to effectively sanitize this multi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 880	Continued From page 32	F 880		

resident use glucometer to prevent the spread of infection among the residents' of the facility.

- Observation, on 08/04/22 at 09:24 AM, revealed Licensed Nurse (LN) J, donned PPE to administer medications to Resident (R)54 in droplet isolation for exposure to COVID. LN J entered the resident's room and set the resident's inhaler, box that contained Simbrinza eye drops (medication to the eye used to treat high pressure in the eye due to glaucoma [abnormal condition of elevated pressure within an eye caused by obstruction to the outflow]), Lantus insulin pens, and Novolog insulin pens on a paper towel on the resident's bedside table. After the resident used the inhaler, eye drops, and insulin pens, LN J placed them directly on the resident's table. Upon exit of the room, LN placed these medications directly on the medication cart.

Interview, on 08/04/22 at 09:40 AM, with LN J, revealed she should sanitize the eye drop box, insulin pens and inhaler with an alcohol wipe.

Interview, on 08/04/22 at 10:30 AM with Administrative Nurse F, revealed she would expect nursing staff to sanitize anything that came in contact with a surface in a droplet isolation room with an appropriate sanitizer.

The facility's policy for "Infection Control and Cleaning of Non-Critical, Reusable Resident Care Equipment," dated 03/03/21, instructed staff to clean equipment immediately after use on residents with contact precautions. Staff were instructed to follow product recommendations for disinfectants/sanitizing agents and instructed staff to clean and disinfect the insulin pens per the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175516	A. BUILDING _____ B. WING _____	08/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KANSAS VETERANS HOME	1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156

(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 880	Continued From page 33 manufacturer recommendations. The facility failed to ensure staff disinfected the multi resident use glucometer and failed to ensure staff administered an inhaler, insulin and eye drops to a resident in isolation were sanitized in an effective manner before returning them to the medication cart to prevent cross contamination.	F 880		