STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B087184	A. BUILDING: _____ B. WING _____	05/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HOME	1425 N STRATFORD LANE WICHITA, KS 67206

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S 000	INITIAL COMMENTS The following cittions represent the findings of a resurvey for the above named Home Plus facility conducted on 05/03/2022.	S 000		
S5155 SS=G	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(a) The facility reported a census of seven residents, with 3 included in the sample. Based on observation, interview, and record review the operator failed to ensure a Licensed Nurse (LN) provided and coordinated the provision of necessary health care services to meet the needs of Resident (R) 504 based on his "Negotiated Service Agreement", which identified the resident needed wound care services. Findings included: - Review of R504's medical record revealed he moved into the facility on 03/18/22 with diagnoses of diabetes type two, left sided weakness, and dementia.	S5155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S5155	Continued From page 1	S5155		

R504's "Functional Capacity Screen" dated 03/18/22 revealed the resident could not complete the task of bathing and dressing and needed physical assistance with toileting and transfers. It also identified the resident as being incontinent of urine.

R504's "Negotiated Service Agreement" (NSA) dated 04/04/22, 18 days after admission, directed one staff to assist with bathing, dressing, toileting, and transfers. It also identified the resident required Home Health for wound care as needed related to a non-healing wound to the left coccyx, identified as a pressure sore. The NSA included multiple "Care Plans" for different health care needs, but failed to include services related to the resident having an open wound.

Review of the R504's "Nursing Progress Notes" dated 03/18/22 revealed the resident moved into the facility and had a red/open area on his bottom that measured 2 centimeters (cm). Staff documented the wound as a stage 1 pressure injury (intact skin with a localized area of non-blanchable redness).

On 04/25/22 "Nursing Progress Note" revealed the medical provider was in the facility, assessed the wound, identified it as not healing, and gave new orders for Home Health wound care.

Review of the "Medical Providers Progress Notes" dated 03/29/22 included "wound as described in nurses notes".

Review of the "Medical Providers Progress Notes" dated 04/25/22 included the resident's wound on left hip noted as pink/red, no defined border, and a stage two. "Wound on left buttock appears to be a healing pressure wound. It is dry

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S5155	Continued From page 2	S5155		

without drainage. No one seems to know exactly where and how he got these wounds. Discussed treatment."

Review of the "Decubitus/Skin Conditions" form revealed the following documentation related to left buttock wound:
03/18/22 - The area measured 2 centimeters and noted as a stage1.
03/21/22 - No changes noted.
03/28/22 - No changes noted.
04/04/22 - Area scabbed.
04/11/22 - No changes noted.
04/18/22 - Area noted as scabbed, pink around and with no drainage,
04/25/22 - Area scabbed, red around and the Nurse Practitioner with new order for Home Health wound nurse.

The documentation lacked any measurements of the wound after admission to the facility.

Review of the Home Health skilled nursing documentation on 04/25/22 revealed, "Patient has a pressure ulcer on left buttocks - unable to assess d/t (due to) the wound covered with eschar and tissue - the wound needs debrieded - discussed need to get an order from physician to go to wound clinic".

Observation on 05/03/22 at 10:38 AM when Certified Medication Aide (CMA) B assisted the resident onto the toilet and noted the resident had a thin cushion in his wheelchair. After staff provided peri-care to the resident observation revealed an open wound, which measured approximately 1.5 inches x 1inch with the center deeper than the outer edge and yellowish eschar in the very center at the deepest level. When CMA B finished assisting the resident she took

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S5155	Continued From page 3	S5155		

him to the front room and assisted him into his recliner, which revealed the resident did not have a cushion in his recliner.

The wound increased in size from 2 centimeters and being red to approximately 1.5 inches x 1 inch with a deep opening and yellow eschar in the center at the deepest level.

On 05/03/22 at 01:34 PM Administrative Staff/Licensed Nurse A reported when the Home Health wound nurse came to the facility, she said there was nothing we could do until R504 went to the wound clinic and got new orders for a treatment. She acknowledged that she had not measured the wound since admission. She also acknowledged that the "Negotiated Service Agreement" and the "Health Care Service Plan" did not identify interventions for staff to provide the resident.

On 05/03/22 at 02:24 PM CMA B reported staff had to help with resident with activities of daily living including toileting and transfers in and out of bed. CMA B confirmed the resident had an open sore on his bottom and said that they just put calmoseptine on it and lay him down for about an hour each day. CMA B tried to keep him on his back and elevate his left side a little.

Review of the "Pressure Ulcer Prevention and Care" provided on 05/04/22 as a policy for wound care included the following directions for staff: "Implement prevention plans, develop and implement an individualized, risk-based pressure injury prevention plan. The policy included a list of possible interventions. It also included need to assess existing pressure injuries as it increases risk for developing a new pressure injury. Document the location of existing pressure

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S5155	Continued From page 4 injuries, assess the dimensions and determine the stage using international classification system." Based on observation of R540's open wound, review of his progress notes and documentation of his wound, the operator failed to ensure a Licensed Nurse provided and coordinated the provision of necessary health care services to meet the needs of the resident based on his Negotiated Service Agreement which identified the resident needed wound care services.	S5155		
S5192 SS=F	26-42-206 (e) Food Preparation (e) Food shall be prepared using safe methods that conserve the nutritive value, flavor, and appearance and shall be served at the proper temperature. (1) Food used by facility staff to serve to the residents, including donated food, shall meet all applicable federal, state, and local laws and regulations.(2) Food in cans that have significant defects, including swelling, leakage, punctures, holes, fractures, pitted rust, or denting severe enough to prevent normal stacking or opening with a manual, wheel-type can opener, shall not be used. (3) Food provided by a resident ' s family or friends for individual residents shall not be required to meet federal, state, and local laws and regulations. This REQUIREMENT is not met as evidenced by: KAR 26-42-206(e) The facility reported a census of seven residents.	S5192		

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S5192	Continued From page 5 Based on observations and interview the operator failed to ensure designated staff prepared food using safe methods and served food at the proper temperature. All seven residents ate the facilities food prepared for the noon meal. Findings included: - Observation of noon meal preparation on 05/03/22 at 12:10 PM revealed the following: Certified Medication Aide (CMA) B got plates out of the cabinet and set one for each resident on the kitchen counter. With gloved hands she took a can of mixed fruit and spooned out a portion for each resident. CMA B then took the pan of mashed potatoes off of the stove and put a spoonful on each resident's plate. She took a bowl of cut carrots out of the microwave, added butter and then put a spoonful on each plate. CMA B did not take the temperature of the carrots or potatoes prior to fixing the plates. CMA B then took the chicken out of the oven, got a thermometer out of the drawer and stuck it into a piece of the chicken. When asked what the temperature read she stated 155 degrees Fahrenheit (F) and proceeded to cut the meat up to put on resident's plates. Surveyor intervened and asked CMA B what the cooked temperature for chicken needed to be and she stated it was 155 degrees. Surveyor explained per the "Focus on Food Safety" manual, poultry should be cooked to 165 F. CMA B asked if it needed to be put back in the over. Surveyor confirmed it needed to be cooked to the proper temperature before it could be served. CMA B then reset the oven to 400 degrees and put the chicken tray in the oven. Staff then removed her gloves and proceeded to take other residents to the dining room table. At 12:38 PM CMA B took the chicken	S5192		

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S5192	Continued From page 6	S5192		

out of the oven and checked the temperature again and it still read low. At that point Administrative staff/Licensed Nurse A came into the kitchen and told CMA B to try a different thermometer as that one had to be incorrect. The chicken then read at 197 degrees F. During this whole time the residents plates with the potatoes, carrots and fruit remained sitting on the cabinet for 28 minutes. Surveyor requested CMA B check the temperature of the potatoes and carrots which reveled the potatoes were 97 F and the carrots were in the 80's F. Administrative Staff/Licensed Nurse A then explained to CMA B she needed to remove the fruit and reheat each tray in the microwave so the food read at least 165 degrees, add the fruit and then serve residents.

Review of the food temperature logs revealed documentation for meats served at all three meals but no other food temperatures to ensure proper cooked temperatures/served temperatures.

On 05/03/22 at 3:30 PM Administrative Staff/Licensed Nurse A reported the staff had only been taking the temperature of the meats that are cooked and not any other hot or cold foods served.

Review of the "Focus on Food Safety" dated 2017 provided by Administrative Staff/Licensed Nurse A included directions for "Food Preparation Critical temperatures" which identified minimum hot holding temperature of food as 135 degrees F and the cooked/reheating temperature of poultry was 165 degrees F.

The operator failed to ensure designated staff prepared food using safe methods and served at

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S5192	Continued From page 7 the proper temperature. All seven residents ate the facilities food prepared for the noon meal.	S5192		
S5225 SS=D	26-42-207 (a) (b) (1)(2)(3)(4) Infection Control a) The administrator or operator of each home plus shall ensure the provision of a safe, sanitary, and comfortable environment for residents. (b) Each administrator or operator shall ensure the development of policies and implementation of procedures to prevent the spread of infections. These policies and procedures shall include the following requirements: (1) Using universal precautions to prevent the spread of blood-borne pathogens; (2) techniques to ensure that hand hygiene meets professional health care standards; (3) techniques to ensure that the laundering and handling of soiled and clean linens meet professional health care standards; (4) providing sanitary conditions for food service; This REQUIREMENT is not met as evidenced by: KAR 26-42-207(b)(2) The facility reported a census of seven residents (R). Based on observation, interview, and record review the operator failed to ensure staff implemented procedures to prevent the spread of infections by failing to follow single-use glove guidelines for incontinent care for one (R504) of three sampled residents. Findings included: - Review of R504's medical record revealed he moved into the facility on 03/18/22 with diagnoses	S5225		

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S5225	Continued From page 8	S5225		

of diabetes type two, left sided weakness and dementia.

R504's "Functional Capacity Screen" dated 03/18/22 revealed the resident could not complete the task of bathing and dressing and needed physical assistance with toileting and transfers. It also identified the resident was incontinent of urine.

R504's "Negotiated Service Agreement" dated 04/04/22 directed one staff to assist with bathing, dressing, toileting and transfers.

On 05/03/22 at 10:38 AM Certified Medication Aide (CMA) B took the resident into the bathroom via wheelchair. She put on gloves and then took the resident by the hand and put them on the grab bar explaining that she was going to assist him to stand to use the restroom. CMA B counted to three and then helped lift the resident into a standing position and then turned him to sit on the toilet. R504 started to sit before he was all the way on the toilet. As CMA B tried to sit the resident farther back on the toilet he began to urinate on the floor. CMA B asked another staff to get a pair of pants and then took a piece of toilet paper and put it on the floor with her gloved hands and proceeded to wipe the floor a little. She tried to scoot the resident back farther onto the toilet but R504 would not stand enough to go reposition. With the same gloved hands, CMA B removed the resident's shoes, pants and his pullup and then got some paper towels and wiped the urine off the floor and threw it into the trash. With the same gloved hands, CMA B repositioned the resident on the stool and then proceeded to put on a clean pullup and clean pants without changing her gloves. She then got some more paper towels and wiped the floor again and the

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S5225	Continued From page 9	S5225		

bottom of the resident's shoes. CMA B then assisted the resident to stand up by taking his hand in her same gloved hands and placing them on the grab bar. After the resident stood, staff reached for the cleaning wipes with the same gloved hand used to clean up contaminated floor and wiped the residents bottom which revealed an open wound approximately 1.5 inches x 1inch with the center deeper than the outer edge and with yellowish eschar in the center. CMA B put some calmoseptine ointment on her gloved hand, same one used for cleaning the urine off the floor, and put the calmoseptine on the resident's bottom, covering his open wound. She then removed that glove and then finished cleaning the residents front peri area with her other gloved hand and pulled up the resident's pullup and pants and helped him sit in the wheelchair. She then removed her other glove and took the resident out to the front room to his recliner. After getting resident into his recliner staff washed her hands in the kitchen sink. The CMA failed to change her gloves and wash her hands after cleaning the floor where the resident had urinated.

On 05/03/22 at 05:19 PM CMA C reported that staff were to change their gloves between tasks, including after touching something that was contaminated, such as urine.

On 05/03/22 at 05/19/22 Administrative staff/Licensed Nurse A confirmed staff should have changed her gloves and washed her hands after cleaning the floor and removing soiled clothing, before providing additional cares.

Review of the undated infection control policy directed staff to "wear disposable gloves for contact with any resident's body substances...The

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S5225	Continued From page 10 gloves shall be changed before and after contact with another resident and disposed". It also identifies staff needed to wash hands after removing gloves. The operator failed to ensure designated staff used proper infection control procedures by failing to remove contaminated gloves and washing hands prior to continuing personal care with R504, which included applying an ointment over an open wound.	S5225		