STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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.	F 000		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents with 14 residents sampled, including one resident sampled for dialysis (the clinical purification of blood by dialysis, as a substitute for the normal function of the kidney). Based on observation, interview, and record review, the facility failed to ensure an appropriate system for monitoring fluid intake for one Resident (R)28, related to the resident's fluid restriction. Findings included: - Review of Resident (R)28's electronic medical record (EMR), under the "Med [medication] Diag[diagnosis]" tab, included the following diagnoses: end stage renal disease (condition where the kidney reaches advanced state of loss of function) and dependence on renal dialysis (the clinical purification of blood by dialysis, as a substitute for the normal function of the kidney). The annual "Minimum Data Set" (MDS), dated 07/23/21, documented the resident had a Brief Interview for Mental Status (BIMS) score of five,	F 698		

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
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 698	Continued From page 1	F 698		

indicating severe cognitive impairment. He had no rejection of care and required supervision of one staff for eating. He had a significant weight gain and was not on a physician-prescribed weight-gain regimen. He received dialysis while a resident at the facility.

The "Cognitive Loss/Dementia Care Area Assessment" (CAA), dated 07/23/21, documented the resident had a BIMS of five and a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion).

The quarterly "MDS," dated 01/07/22, documented the resident had a BIMS score of five, indicating severe cognitive impairment. He had no rejection of cares and required supervision with setup help for eating. He had a significant weight gain and was not on a physician-prescribed weight-gain regimen. He received dialysis while a resident at the facility.

The care plan, dated 11/16/16, for Nutrition, instructed staff that dialysis recommended the resident have 32 ounces (oz) but no more than 42-48 oz daily.

Review of the resident's EMR under the "Orders" tab revealed an order for staff to encourage the resident to limit fluid to 1000 ml daily, three times a day (TID). Each meal would be 11.33 oz's (335 milliliter), ordered 10/15/20.

Review of the resident's EMR under the Medication Administration Record (MAR), revealed staff documentation of the fluid intake for the resident by shift. Staff documented 0-12 oz (zero to 354 milliliter) per shift every day from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 698	Continued From page 2 12/01/21 through 01/26/22. On 01/25/22 at 07:43 AM, the resident ate breakfast in the resident dining room. Staff served the resident a 12 oz cup of water, a 12 oz cup of soda, and a 10 oz cup of hot cocoa. The resident consumed all of the soda and hot cocoa, equaling 22 oz's (a total of 650 milliliter) of fluid for the breakfast meal. On 01/26/22 at 07:26 AM, the resident ate breakfast in the resident dining room. Staff served the resident a 12 oz cup of water, a 12 cup of milk, a 10 oz cup of coffee, and a 10 oz cup of hot cocoa (a total of 1,301 milliliters). The resident consumed 23 total oz's (680 milliliters) of fluids with breakfast. On 01/26/22 at 04:12 PM, the resident ate dinner in the resident dining room. Staff served the resident a 12 oz cup of water, a 12 oz cup of soda, and a 10 oz cup of hot cocoa. The resident consumed a total of 22 total oz's (650 milliliters) of fluids with dinner. On 01/25/22 at 11:41 AM, dietary staff CC stated, the resident receives all of these fluids for breakfast and lunch. Staff CC stated he was unaware of how many oz's of fluids the resident could be served at each meal but was to have at least two drinks. Staff CC was not sure who documented the fluid intake for the resident. On 01/25/22 at 04:12 PM, dietary staff DD stated, the resident was on a fluid restriction, but staff would give the resident whatever fluids he wanted with his meals. She was unsure of who documented the resident's fluid intake in the clinical records.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 698	Continued From page 3 On 01/26/22 at 07:32 AM, dietary manager BB stated, the nursing department should document the resident's fluid intake each shift. The resident was to only have 1000 cc's (cubic centimeters/ milliliters), equivalent to 33 oz of fluids per day. On 01/26/22 at 07:59 AM, Certified Medication Aide (CMA) R stated, she documented the resident's fluid intake each shift. CMA stated she documented eight oz's each shift because that was what the resident was "Supposed to have." CMA R verified she "Did not actually look at and figure out the total amount of fluids the resident had each day." On 01/26/22 at 07:15 AM, Licensed Nurse G stated the resident's fluid restriction was not enforced. On 01/26/22 at 01:53 PM, Administrative Nurse D stated, the facility had liberalized diets, meaning the residents were free to have what they wanted. Administrative Nurse D stated the staff should document the actual total amount of fluids the resident consumed each shift. The facility policy for "Hydration Monitoring Protocol", dated 2016, included: Fluids consumed at meals will be documented in addition to meal intake for risk residents on designated form or entered into the appropriate flow sheet within an EMR. The facility failed to effectively monitor this resident, with a fluid restriction, actual fluid intake, as ordered, to ensure the resident had no adverse effects of dialysis.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 4	F 880		
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 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;	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 5 (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 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 29 residents. Based on observation, interview and record review, the facility failed to provide sanitary glucometer (a device used to calculate blood sugar levels cleaning for four Residents (R)11, R15, R22 and R7, failed to provide sanitary cleaning of nebulizer (equipment use to deliver inhaled medication by aerosolization) components for two residents (R) 22 and R20	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 6	F 880		

and failed to ensure proper cleaning techniques of a resident bathroom to prevent the spread of infection.

Findings included:

- Observation on 01/25/22 at 10:42 AM, revealed Licensed Nurse G, obtained blood glucose (blood sugar) with the multi resident use glucometer from resident (R) 11. Following completion of obtaining the specimen, LN G obtained a "PDI Easy Screen " (Professional Disposable International) wipe from the treatment cart and wiped the glucometer with it and placed the glucometer back in the cart.

Interview, at that time with Licensed Nurse G, confirmed she used these wipes to sanitize the glucometer between residents, and thought the "wet time" was 3-5 seconds. The "PDI Easy Screen" wipes manufacturer instructions indicated the wipes removed dirt and grim from touched surfaces, and the ingredients were 70 percent isopropyl alchohol and purified water

Observation, on 01/25/22 at 10:50 AM, revealed LN G obtained a blood glucose sample from R15 with the same glucometer used for R11. After obtaining the sample, LN G used an alcohol wipe to clean the glucometer.

Observation, on 01/25/22 at 11:00 AM, revealed LN G obtained a blood glucose sample from R22 with same glucometer. Upon completion of the blood glucose test, LN G wiped the glucometer with an alcohol wipe.

Interview, at that time with LN G revealed she thought the alcohol wipes were effective for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 7	F 880		

sanitizing the glucometer. LN G stated she had obtained the blood glucose from R7 prior to obtaining R 11's blood glucose.

Interview, on 01/25/22 at 01:00 PM with Administrative Staff A, revealed staff should follow the glucometer's manufactures' recommendation to sanitize the glucometer but the facility used a similar product "Sani wipes" purple top, (a disinfectant wipe that cleans and disinfects in 15 seconds).

Interview, on 01/26/22 at 3:30 PM, with Administrative Nurse D, revealed she would expect staff to use the proper disinfecting wipe to clean the glucometer between resident use.

The " Cleaning and Disinfecting Guide by McKesson Quintet AC Blood Glucose Meters" recommended staff clean and disinfect the meter with a "CaviWipe" disinfecting towelette (a multi-purpose disinfectant for use on hard, non-porous surfaces which is effective in killing bacteria, viruses and fungi in 1 minute.)

The facility failed to ensure staff properly disinfected the glucometer used by four residents to prevent the spread of blood-borne infection.

- Observation, on 01/26/2022 at 09:00 AM, housekeeping staff V, prepared to clean an unidentified resident's bathroom fixtures with a dry disposable towelette. Staff V wiped the sink and fixtures. Staff V dipped the same towelette inside the toilet bowl with her gloves on and she stated she sprayed the inside of the toilet bowl with a bleach solution and thought it was now

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 8	F 880		

sanitary to use this water to wet her towelette. Staff V then wiped the toilet seat and the outside of the toilet and with the same towelette and same gloves, and she wiped the handrails next to the toilet. Staff V then removed the gloves without sanitizing her hand afterwards and continued to another resident's room.

Interview on 01/26/22, at 02:30 PM, with Administrative staff A, revealed staff should not dip the cleaning wipes inside the toilet to wet them.

The facility's policy for "Housekeeping" policy, instructed staff to maintain the facility in a clean, safe, comfortable, and sanitary manner. The policy also instructed staff to clean and sanitize the tank, seat and the bowl and base and to use bowl cleaner only on the inside of the toilet bowl.

The "Hand Hygiene" policy, dated 10/19/19, instructed staff to perform hand hygiene prior to donning gloves and immediately after removing gloves.

The facility failed to ensure staff cleaned resident bathroom fixtures (handrails), toilet seat, and outer area of the toilet in a sanitary manner and failed to perform hand sanitization after removal of gloves to prevent spread of infection.

- Review of Resident (R)22's Electronic Medical Record (EMR) under the "Orders" tab, revealed a physician's order for Ipratropium-Albuterol Solution 0.5-2.5 (3) milligram (mg)/3 millimeter (ml). Inhale orally three times a day (TID) for chronic obstructive pulmonary disease (COPD-progressive and irreversible condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 9	F 880		

characterized by diminished lung capacity and difficulty or discomfort in breathing), ordered 01/11/22, located in the resident's Medication Administration Record (MAR).

On 01/26/22 at 07:01 AM, Licensed Nurse (LN) D, entered Resident (R)22's room to administer a breathing treatment. The nebulizer facemask rested on the resident's bed side table, in one piece, uncovered. LN D put the medication into the medication barrel of the mouthpiece and handed the mouthpiece, dated 01/25/22, to the resident to hold during the treatment.

On 01/26/22 at 07:19 AM, when the breathing treatment completed, LN D entered the resident's room. LN D took the mouthpiece from the resident, took it apart, and placed the multiple components into a clear plastic container with a paper towel on the bottom. LN D failed to rinse or wash any components of the mouthpiece.

On 01/26/22 at 07:19 AM, LN D stated, the nebulizer mouthpieces are cleaned on the night shift. She reported she was not to rinse or wash any parts of the mouthpiece following a nebulizer treatment.

On 01/26/22 at 01:53 PM, Administrative Nurse D stated, staff should clean the mouthpiece of a nebulizer by rinsing the reservoir with hot water and cleaning the mouthpiece with soap and water after each use. The components were to be stored in the plastic container with a clean, dry paper towel. Administrative Nurse D confirmed the cleaning had not been done properly.

The facility policy for "Respiratory Therapy", dated 01/2019, included: After treatment, rinse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 10	F 880		

medication fill line with warm tap water then wash mask with warm water and antimicrobial soap.

The facility failed to properly clean the mouthpiece of the nebulizer for this resident to prevent possible respiratory infections.

- Review of Resident (R)20's "Physician Order Sheet" (POS), dated 01/21/22, revealed a physician's order for Albuterol Sulfate Nebulizer 2.5 (3) milligram (mg)/3 millimeter (ml). Inhale orally every six hours, as needed (RN), for cough, ordered 01/06/22.

On 01/26/22 at 06:45 AM, the resident lay in bed with the nebulizer breathing treatment being given. The resident had the mouthpiece on her face.

On 01/26/22 at 06:59 AM, Certified Nurse Aide (CNA) M, entered the resident's room to get her ready for the day. CNA M removed the mouthpiece and placed it on the bed side table on top of a paper towel.

On 01/26/22 at 07:24 AM, Licensed Nurse (LN) G, entered the resident's room to check her following the breathing treatment. LN G took the mouthpiece, disconnected it and put the individual components on a paper towel on the bed side table. LN G did not clean any of the individual components from the mouthpiece.

On 01/26/22 at 07:24 AM, LN D stated, the nebulizer mouthpieces are cleaned on the night shift. She reported she was not to rinse or wash any parts of the mouthpiece following a nebulizer treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 11 On 01/26/22 at 01:53 PM, Administrative Nurse D stated, staff should clean the mouthpiece of a nebulizer by rinsing the reservoir with hot water and cleaning the mouthpiece with soap and water after each use. The components were to be stored in the plastic container with a clean, dry paper towel. Administrative Nurse D confirmed the cleaning had not been done properly. The facility policy for "Respiratory Therapy", dated 01/2019, included: After treatment, rinse medication fill line with warm tap water then wash mask with warm water and antimicrobial soap. The facility failed to properly clean the mouthpiece of the nebulizer for this resident to prevent possible respiratory infections.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents. Based on interview and record review, the facility failed to ensure principles of antibiotic stewardship would be followed by nursing staff to ensure antibiotics used in a safe and effective manner to prevent unnecessary side effects of	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 881	Continued From page 12	F 881		

antibiotics and antibiotic resistance in an ongoing, proactive manner.

Findings included:

-Review of the "Infection Control Log" for tracking and trending infections from January 2021 through January 2022, revealed lack of Infection Control Logs for January 2021 thru April 2021. The Infection Control logs reviewed lacked complete data for analysis of adherence with an evidenced-based surveillance criterion to define infections and effectiveness of the facility's antibiotic stewardship program. The logs revealed incomplete documentation of culture results of organism identification for monitoring trends in infections.

Review of the January 2021 antibiotic use on the "Order Listing Report", revealed one resident (R14) prescribed antibiotics without evidence of the "Infection Control Log" completed.

Review of the February 2021 antibiotic use on the "Order Listing Report", revealed four residents (R18, R21, R29, R9) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the residents are prescribed the appropriate antibiotic.

Review of the March 2021 antibiotic use on the "Order Listing Report", revealed four residents (R18, R21, R7, R26) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the residents are prescribed the appropriate antibiotic.

Review of the April 2021 antibiotic use on the "Order Listing Report", revealed three residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 881	Continued From page 13	F 881		

(R21, R7, R12) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the residents are prescribed the appropriate antibiotic.

Review of the May and June 2021 "Infection Control Log" lacked organism identification for two residents each, treated with antibiotics. The June Log lacked indication if culture was completed/results for two documented residents (R19, R7)

Review of July 2021 antibiotic use on the "Order Listing Report", revealed four residents (R18 with two separate infections for July, R181, R9, R24) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the residents are prescribed the appropriate antibiotic. The July Log lacked indication if culture was completed/results for two residents (R 18, R 24)

Review of August 2021 "antibiotic use on the "Order Listing Report", revealed one resident (R19) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the resident prescribed the appropriate antibiotic. The Log lacked indication if culture was completed/results for one resident (R22).

Review of the September 2021 "Infection Control Log" lacked evidence of organism identification for one resident (R22) treated with antibiotics.

Review of October 2021 antibiotic use on the "Order Listing Report", revealed one resident (R9) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the resident prescribed the appropriate antibiotic.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 881	Continued From page 14	F 881		

Review of November 2021 antibiotic use on the "Order Listing Report", revealed two residents (R26 with 2 separate infections and R 18) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the residents are prescribed the appropriate antibiotic.

Review of December 2021 antibiotic use on the "Order Listing Report", revealed two residents (R18, R7) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the residents are prescribed the appropriate antibiotic.

Review of January 2022 antibiotic use on the "Order Listing Report", revealed three residents (R22, R3, R2) prescribed antibiotics without evidence of the "Infection Control Log" completed to ensure the residents are prescribed the appropriate antibiotic.

Interview, on 01/26/2022 at 02:45 PM, with nurse Licensed Nurse (LN) G, revealed she was unfamiliar with an evidenced-based surveillance criterion to define infections and had not utilized one at the facility.

Interview, on 01/26/2022 at 02:30 PM, with Administrative staff A and Administrative Nurse E, revealed there was a change in the process of keeping paper logs following a change in staff. Administrative staff A responsible to maintain the logs on the computer. Administrative Nurse E stated there was a "Glitch in the computer" and failed to provide the requested Infection Control Logs for January 2012 thru April 2021. Administrative Nurse E further confirmed the logs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175468	A. BUILDING _____ B. WING _____	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE MISSION RETIREMENT VILLAGE	242 CARROLL STREET SAINT PAUL, KS 66771

(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 881	Continued From page 15 lacked data. Administrative Nurse E stated she ran an antibiotic report weekly or monthly and confirmed that the logs lacked complete data of the infections. Administrative nurse E stated she reviewed the "Antibiotic report" weekly or monthly. The facility policy "Infection Prevention and Control Program" revised 12/04/2017,instructed staff with clinical oversight responsibilities were to monitor antibiotic use as part of the antibiotic stewardship program and to establish and maintain an infection prevention and control program designed to help prevent development and transmission of communicable diseases and infections. The facility failed to proactively apply the principles of antibiotic stewardship, for the residents of the facility from January 2021 thru January 2022 to ensure antibiotics administered in a safe and effective manner to prevent unnecessary side effects of antibiotics and antibiotic resistance.	F 881		