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	175379	A. BUILDING _____ B. WING _____	C 09/08/2021

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MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigations KS00150652 and KS00161750. The 2567 was electronically sent on 09/16/21.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents with 20 included in the sample. Based on observation, interview, and record review the facility failed place urinary drainage bags in dignity bags to keep the drainage bag away from public view for Residents (R) 38 and R 9.

Findings included:

- R38's "Physician Orders" dated 03/22/21 revealed the following diagnoses: neurogenic bladder, (dysfunction of the urinary bladder caused by a lesion of the nervous system), overactive bladder (bladder control problem which leads to a sudden urge to urinate), and chronic kidney disease (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes).

The "Annual Minimum Data Set" (MDS) dated 11/13/20 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 indicating intact cognition. The resident required extensive assistance of two staff for bed mobility and transfers. The resident had an indwelling urinary catheter. The resident received diuretic medications.

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The "Quarterly Minimum data set (MDS) dated 07/05/21 revealed a BIMS of 11 indicating moderate cognitive impairment. The resident had no changes in daily care. The resident had an indwelling urinary catheter. The resident received diuretic medications.

The "Urinary Incontinence/Catheter Care Area Assessment" (CAA) dated 11/13/20 revealed the resident had an indwelling urinary catheter in place to assist with her neurogenic bladder. She required staff assist to maintain and manage the catheter. Licensed Nurse to change the catheter monthly per order.

Review of the "Care Plan" dated 07/19/21 revealed the resident had a urinary catheter due to a neurogenic bladder. Interventions directed staff to change the catheter per order.

Observation on 09/01/21 at 11:03 AM revealed the resident lying in bed waiting for the lunch meal. The resident had a catheter drainage bag with urine visible in the bag hanging on the side of the bed and no dignity bag used to cover the urine collection bag. The bag containing urine was visible from the hallway.

Observation on 09/02/21 at 01:20 PM revealed the resident lying in bed in a semi- fowler (laying with head elevated) position. The resident's catheter bag hung from the side of the bed with no dignity bag in place and urine visible in the bag from the hallway.

Observation on 09/07/21 at 07:19 AM revealed the resident's catheter bag hanging from side of bed without a dignity bag.

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Observation on 09/07/21 at 10:00 AM revealed the resident lay in bed watching television. Her catheter bag visibly hhanging on the side of the bed with no dignity bag on the drainage bag.

During an interview on 09/02/21 the resident reported she had the catheter for a long while. Staff take care of all the care for it but did not remember a dignity bag being used.

During an interview on 09/07/21 at 04:03 PM CNA H acknowledged no dignity bag was on the catheter drainage bag and she was not sure why.

During an interview on 09/07/21 at 04:30 PM Licensed Nurse C reported all catheter bags were to be in a dignity bag with a tub underneath to prevent it from touching the floor. She was not aware of the resident not having a dignity bag.

During an interview on 09/08/21 at 12:15 PM Administrative Nurse A reported all catheters always need to be kept off the floor and in a dignity bag.

The Facility Policy for "Catheter Care" dated 11/19 revealed to keep drainage bag below level of the resident's bladder and keep the bag and tubing off the floor. Place the drainage bag into a cover bag for dignity both at bedside and in the wheelchair.

The facility failed to place R 38's urinary drainage bag in a dignity bag.

- R9's signed "Physician Orders" dated 07/21/21 revealed the following diagnoses: neuromuscular dysfunction of bladder, (dysfunction of the urinary

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bladder caused by a lesion of the nervous system), and overactive bladder (bladder control problem which leads to a sudden urge to urinate).

The "Annual Minimum Data Set" (MDS) dated 03/26/21 revealed a "Brief Interview for Mental Status" (BIMS) score of five indicating severe cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfers, hygiene, dressing and bathing. The resident had an indwelling foley catheter.

The "Quarterly MDS" dated 06/26/21 revealed a BIMS of three indicating severe cognitive impairment with no changes in daily cares. The resident continued with a catheter.

The "Urinary Incontinence/Indwelling Catheter CAA Care Area Assessment" (CAA) dated 03/26/21 revealed the resident required total assistance for catheter management and care.

Review of the "Care Plan" dated 07/21/21 revealed R9 had a suprapubic catheter (a catheter inserted into bladder through abdominal wall) with diagnosis of neurogenic bladder. He had potential for infection and catheter related complications.
Interventions included the following:
Keep catheter bag below bladder level. Keep tubing and drainage bag from touching floor.
Monitor urine appearance, amount, odor and clarity
Maintain a closed, sterile, system, tubing free of kinks.
Secure catheter tubing to upper leg with leg strap to prevent catheter begin pulled out.
Change catheter monthly and as needed per physician orders

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Provide and encourage fluids of choice. Appointment with Urologist as scheduled and as needed.

Observation on 09/01/21 at 08:32 AM revealed the resident lying in bed awake and restless. The resident had an indwelling catheter without a dignity bag and hanging off the end of the bed onto the floor.

During an interview on 09/01/21 at 08:32 AM Certified Nursing Assistant (CNA) G reported residents with catheters usually had a dignity bag the drainage bag went in. She was unsure why the resident did not use one on his catheter. She did not remember seeing one used with the resident.

During an interview on 09/07/21 at 10:45 AM CNA O reported the resident had a catheter staff emptied at the end of the shift and when needed. The (Licensed Nurse) LN took care of the catheter not the CNAs because it was a suprapubic catheter.

During an interview on 09/07/21 at 3:55 PM LN C reported all catheter bags were to be in dignity bags and his bag should not have been on the floor.

During an interview on 09/08/21 at 12:15 PM Administrative Nurse A reported all catheters always need to be kept off the floor and in a dignity bag.

The Facility Policy for "Catheter Care" dated 11/19 revealed to keep drainage bag below level of the resident's bladder and keep the bag and tubing off the floor. Place the drainage bag into a

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F 550	Continued From page 6 cover bag for dignity both at bedside and in the wheelchair. The facility failed to place R9's urinary drainage bag in a dignity bag.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		

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this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and

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email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 77 residents with 20 sampled, including one for hospitalization. Based on observation, interview, and record review the facility failed to send a copy of the facility-initiated hospitalization transfer/discharge notice to the representative of the Office of the State Long-Term Care Ombudsman for Resident (R) 39.

Findings included:

- R39's "Minimum Data Set" (MDS) tracking form dated August 2021 revealed the resident discharged to the hospital on 07/31/20 and

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F 623	Continued From page 9 returned to the facility on 08/06/21. Review of R39's "Electronic Health Record" (EHR) lacked evidence of written notification of the facility-initiated hospitalization transfer/discharge and bed hold to R39's Office of the State Long-Term Care Ombudsman. Observation of 09/02/21 at 03:06 PM R39 sat in the day room in her wheelchair actively watching television, and the staff checked on R39 often. On 09/08/21 at 11:50 AM a request for logs of R39's transfers from the facility to the hospital in the time period July 2021 to August 2021, Medical Records staff K reported the facility failed to complete such transfer logs. She stated she had only the residents who discharged home or transferred to the hospital that did not "live here" on her log that she transmitted to the Office of the State Long-Term Care Ombudsman. Interview with Administrative Nurse A on 09/08/21 at 12:15 PM revealed she expected staff to send the logs of hospital transfers to the State Ombudsmen's office monthly. The 09/21 "Administration" policy documented staff will send a monthly summary of all discharges from the facility to the State and Regional Ombudsman. The facility failed to send a copy of the notice of facility-initiated hospitalization transfer/discharge to a representative of the Office of the State Long-Term Care Ombudsman when R39 transferred to the hospital.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		

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F 625	Continued From page 10 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 77 residents with 20 sampled including one for hospitalization. Based on observation, interview, and record review the facility failed to provide a copy of the facility bed hold policy to Resident (R) 39 or her representative for her 07/31/21 facility-initiated hospitalization.	F 625		

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Findings Include:

- Review of R39's "Minimum Data Set" (MDS) tracking form dated August 2021 revealed the resident discharged to the hospital on 07/31/21 and returned to the facility on 08/06/21.

Review of R39's "Electronic Health Record" lacked evidence of written notification of the facility-initiated hospitalization transfer and bed hold to R39 or her representative.

Observation of 09/02/21 at 03:06 PM R39 sat in the day room in her wheelchair actively watching television, and the staff checked on R39 often.

On 09/08/21 at 11:37 AM Social Services Designee (SSD) Staff J stated the bed holds were done at the time of the admission to the nursing facility and the facility did not give a bed hold policy to the resident or representative at the time of hospitalization. She stated the life enhancement staff contacted the resident or their family for updates on anticipated return to the facility.

On 09/08/21 at 11:40 AM Medical Record Staff K stated the life enhancement staff took care of the bed hold policy when residents were transferred to the hospital and stated they called the resident or representative to check on their plans to return to the facility. Medical Record Staff K stated the facility did hold the resident's bed for them.

On 09/08/21 at 11:46 AM Life Enhancement/SSD Staff W stated the facility gave the resident or resident representative a copy of the bed hold policy at the time of admission to the facility, and

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F 625	Continued From page 12 if the resident was gone long enough, she called or emailed them to check on their plan to continue residence at the facility or not. On 09/08/21 at 11:49 AM Licensed Nurse X stated she did not give the bed hold policy to a resident at the time of a hospitalization transfer. On 09/08/21 at 12:15 PM Administrative Nurse A reported she thought Life Enhancement/SSD staff took care of the bed hold policies when residents transferred to the hospital and did not think nurses sent those out. Administrative Nurse A did not know the facility were not sending a copy of the bed hold policy to the resident or responsible party when a resident admitted to the hospital. The 06/18 "Bed-Hold/ Readmission Policy" documented all residents are made aware of facility's bed-hold policy and reserve bed payment policy before and upon transfer to a hospital or when taking a therapeutic leave of absence. The facility failed to provide a copy of the bed hold policy for R39 or her representative for her 07/31/21 hospitalization.	F 625		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates.	F 640		

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(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
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(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and

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approved by CMS.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 77 residents with 18 residents in the sample. Based on interview and record review the facility failed to transmit Minimum Data Set (MDS) assessments to Centers for Medicare & Medicaid Services (CMS) in a timely manner for four residents reviewed. Residents (R)9, R4, R2, and R5.

Findings included:

- Record review on 09/07/21 at 09:17 AM revealed:
R5's "Death in Facility MDS" completed on 05/19/21 and no transmission date
R2's "Quarterly MDS" signed as complete on 06/25/21 and no transmission date
R4's "Quarterly MDS" signed as complete on 07/02/21 and no transmission date
R9's "Quarterly MDS" signed as complete on 07/06/21 and no transmission date

During an interview on 09/07/21 at 03:00 PM Administrative Nurse D acknowledged the assessments were not submitted to CMS in a timely manner. She reported she did not know if she transmitted the assessments or if the other MDS Coordinator or the DON transmitted them.

During an interview on 09/07/21 at 03:10 PM Administrative Nurse A reported it was Administrative Nurse E who transmitted the MDS and Administrative Nurse A thought she did it weekly, but would check on why the assessments were not transmitted.

Review of the facility's policy for "MDS Process"

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F 640	Continued From page 15 dated 11/19 revealed the facility would follow the "3.0 RAI [Resident Assessment Instrument] Manual" for completion and submission of the MDS for each resident. According to the "3.0 RAI Manual," dated October 2019, all Medicare and/or Medicaid-certified nursing homes must transmit required MDS data records to CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date +14 days. All other MDS assessments must be submitted within 14 days of the MDS Completion Date + 14 days. The facility failed to transmit Minimum Data Set (MDS) assessments to CMS in a timely manner for four residents reviewed.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 77 residents, with 20 included in the sample, and one resident reviewed for oxygen use. Based on interview, observation, and record review, the facility failed to ensure the care plan included information on the use of oxygen for Resident (R) 186.

Findings included:

- Review of R186's "Electronic Health Record" (EHR) revealed the following diagnoses: acute respiratory failure with hypoxia (inadequate

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supply of oxygen) or hypercapnia (excessive carbon dioxide in the bloodstream), sleep apnea (disorder of sleep characterized by periods without respirations), and acute pulmonary edema (accumulation of extravascular fluid in the lung tissues).

The "Admission Minimum Data Set" (MDS) dated 08/14/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 14 which indicated intact cognition. R186 received oxygen therapy.

The "Activities of Daily Living (ADL)/ Rehabilitation Potential Care Area Assessment (CAA)" dated 08/14/21 revealed R186 admitted with diagnoses of pulmonary edema and respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide).

R186's "Care Plan" lacked staff interventions relevant to respiratory care for the resident, to include oxygen use, oxygen tubing, or bubbler humidifier.

The "Physician Orders" dated 08/07/21 revealed an order for use of an oxygen concentrator, and included to wash the filters weekly with warm, soapy water, rinse well, and pat dry. The orders further noted to change the oxygen tubing and humidifier bottle weekly on Sunday.

The Physician Orders" dated 08/07/21 revealed on order for oxygen at two liters per minute via nasal cannula continuously for respiratory failure.

Observation on 09/02/21 at 11:51 AM of R186's room revealed the resident was not in his room and his oxygen tubing connected to the oxygen

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concentrator was not stored in a plastic bag but was set down on his recliner. Further observation revealed the date on the bubbler humidifier bottle read 08/15/21, which indicated the oxygen tubing and humidifier were last changed out 18 days ago.

During an interview on 09/07/21 at 03:44 PM, Certified Medication Aide (CMA) N stated R186 used oxygen continuously. CMA N stated the CMA's were responsible for changing out tubing and the bubbler and thought this should be done weekly. CMA N stated there should be a bag connected to the concentrator in which the tubing should be stored when not in use.

During an interview on 09/08/21 at 09:53 AM, Licensed Nurse (LN) M stated R186 used oxygen continuously. LN M stated the LN or the CMA's were responsible for replacing the oxygen tubing but did not know how often it should be changed. LN M stated the tubing and bubbler should be dated when it was changed, and the tubing should be kept with the portable oxygen tank or the oxygen concentrator when not in use but did not know if the tubing should be stored in a plastic bag when not in use.

During an interview on 09/08/21 at 01:07 PM, Administrative Nurse D stated she was not sure if R186 used oxygen. Administrative Nurse D stated that if a resident used oxygen this should be included in the care plan. Administrative Staff D verified that there was nothing listed on R186's care plan that indicated he used oxygen.

During an interview on 09/08/21 at 09:01 AM, Administrative Nurse A stated the use of oxygen should be included in a resident's care plan.

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F 656	Continued From page 19 Review of the "Comprehensive Care Plan" policy dated 11/19 revealed, "MFC will ensure that each resident will have a person-centered comprehensive care plan developed and implemented to meet his/her other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. " The facility failed to ensure the care plan included information about the use of oxygen for R186.	F 656		
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 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	F 690		

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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 77 residents with 20 included in the sample, and two reviewed for urinary catheter. Based on observation, interview, and record review the facility failed to provide necessary services to decrease the risk of a urinary tract infection when the staff failed to ensure Resident (R) 9's urinary catheter drainage bag did not come in direct contact with the floor.

Findings included:

- R9's signed "Physician Orders" dated 07/21/21 revealed the following diagnoses: neuromuscular dysfunction of bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system) and overactive bladder (bladder control problem which leads to a sudden urge to urinate).

The "Annual Minimum Data Set" (MDS) dated 03/26/21 revealed a Brief Interview for Mental Status (BIMS) score of five, indicating severe cognitive impairment. The resident required extensive assistance of two staff for bed mobility, transfers, hygiene, dressing, and bathing. The resident had an indwelling urinary catheter.

The "Quarterly MDS" dated 06/26/21 revealed a

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BIMS of three, indicating severe cognitive impairment and the resident continued with a urinary catheter.

The "Urinary Incontinence/Indwelling Catheter CAA Care Area Assessment" (CAA) dated 03/26/21 revealed the resident required total assistance for catheter management and care.

Review of the "Care Plan" dated 07/21/21 revealed R9 had a suprapubic catheter (a catheter inserted into bladder through abdominal wall) with diagnosis of neurogenic bladder. He had potential for infection and catheter related complications. The care plan interventions included the to keep the catheter bag below the bladder level and to keep the tubing and drainage bag from touching the floor.

Observation on 09/01/21 at 08:32 AM revealed the resident in bed, awake and restless. The resident had an indwelling catheter (without a dignity bag cover) and hanging off the end of the bed, with the drainage bag touching the floor.

During an interview on 09/01/21 at 08:40 AM Certified Nurse Aide (CNA) G reported the urinary catheter drainage bag should never be touching the floor.

During an interview on 09/07/21 at 10:45 AM CNA O reported the Licensed Nurse (LN) took care of the catheter, not the CNA's, because it was a suprapubic catheter (catheter entering bladder through hole in abdomen). CNA O said if the catheter bag hung too low, there should be a tub by his bed to put the urinary catheter drainage bag in, to keep it off the floor.

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F 690	Continued From page 22 During an interview on 09/07/21 at 03:55 PM LN C reported the resident's catheter bag should not have be on the floor at any time. During an interview on 09/08/21 at 12:15 PM Administrative Nurse A reported all urinary catheters always needed to be kept off the floor. The facility failed to provide necessary services to decrease the risk of a urinary tract infection when staff failed to ensure R9's urinary catheter drainage bag did not rest on the floor beside his bed.	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 census totaled 77 residents, with 20 included in the sample, and one resident reviewed for oxygen use. Based on observation, interview, and record review the facility failed to ensure staff changed out the oxygen tubing and the bubbler humidifier as scheduled and failed to ensure staff properly/sanitarily stored the residents oxygen tubing when not in use for Resident (R)186. Findings included:	F 695		

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- Review of R186's "Electronic Health Record" (EHR) revealed the following diagnoses: acute respiratory failure with hypoxia (inadequate supply of oxygen) or hypercapnia (excessive carbon dioxide in the bloodstream), sleep apnea (disorder of sleep characterized by periods without respirations), and acute pulmonary edema (accumulation of extravascular fluid in the lung tissues).

The "Admission Minimum Data Set" (MDS) dated 08/14/21 revealed a "Brief Interview for Mental Status" (BIMS) score of 14 which indicated intact cognition. R186 received oxygen therapy.

The "Activities of Daily Living (ADL)/ Rehabilitation Potential Care Area Assessment (CAA)" dated 08/14/21 revealed R186 admitted with diagnoses of pulmonary edema and respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide).

R186's "Care Plan" lacked staff interventions relevant to respiratory care for the resident, to include oxygen use, oxygen tubing, or bubbler humidifier.

The "Physician Orders" dated 08/07/21 revealed an order for use of an oxygen concentrator, and included to wash the filters weekly with warm, soapy water, rinse well, and pat dry. The orders further noted to change the oxygen tubing and humidifier bottle weekly on Sunday.

Observation on 09/02/21 at 11:51 AM of R186's room revealed the resident was not in his room and his oxygen tubing connected to the oxygen

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concentrator was not stored in a plastic bag but was set down on his recliner. Further observation revealed the date on the bubbler humidifier bottle read 08/15/21, which indicated the oxygen tubing and humidifier were last changed out 18 days ago.

During an interview on 09/07/21 at 03:44 PM, Certified Medication Aide (CMA) N stated R186 used oxygen continuously. CMA N stated the CMA's were responsible for changing out tubing and the bubbler and thought this should be done weekly. CMA N stated there should be a bag connected to the concentrator in which the tubing should be stored when not in use.

During an interview on 09/08/21 at 09:53 AM, Licensed Nurse (LN) M stated R186 used oxygen continuously. LN M stated the LN or the CMA's were responsible for replacing the oxygen tubing but did not know how often it should be changed. LN M stated the tubing and bubbler should be dated when it was changed, and the tubing should be kept with the portable oxygen tank or the oxygen concentrator when not in use, but did not know if the tubing should be stored in a plastic bag when not in use.

During an interview on 09/08/21 at 09:01 AM Administrative Nurse A stated the oxygen tubing and bubbler should be changed out weekly by the either the LN or CMA. Administrative Nurse A stated when the oxygen tubing was not in use it should be stored in a plastic bag located on the oxygen concentrator.

Review of the "Oxygen Therapy" policy dated 09/21 revealed, "Change tubing and cannula or mask, and humidifier bottle weekly." The policy

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F 695	Continued From page 25 did not mention how the tubing should be stored when not in use. Review of the "Nebulizer Equipment Care" policy dated 10/19 revealed, "When not in use ensure tubing is stored in a plastic bag..." The facility failed to ensure the oxygen tubing and bubble humidifier were changed out weekly as ordered and failed to ensure the staff stored the resident's oxygen tubing in accordance with sanitary practices, when not in use.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility reported a census of 77 residents, with one main kitchen. Based on observation,	F 812		

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interview, and record review the facility failed to store foods and dishes in a safe and sanitary manner by the failure of staff to perform hand hygiene and use gloves appropriately in the kitchen and during meal service.

Findings included:

- On 09/01/21 at 08:35 AM during initial tour of the main kitchen the following were observed:
In the walk-in refrigerator, noted one eight-ounce (oz) boost breeze with a use by date of 06/29/21, one eight oz boost breeze with a use by date of 08/10/21, one eight oz ensure plus with a use by date of 08/01/21. Dietary Staff (DS) R removed these items. One stack of 12 different sized metal bowls were stacked upright.

On 09/01/21 at 08:35 AM DS U stated, "that is the way we always stack them."

On 09/01/21 at 09:10 AM DS Y prepared spinach for the noon meal and had frozen spinach in a pan. DS Y then took an unopened bag of frozen spinach and placed it on top of the open raw spinach in the pan and cut it open to add to the open raw spinach. Placing the plastic bag from the freezer box onto the raw frozen open spinach.

During an interview on 09/01/21 at 09:10 AM DS Y revealed she thought that was the way the spinach should be done. She stated the plastic from the unopened bag was hard to hold and placing it on the open spinach would stop the fluid from leaking everywhere.

On 09/01/21 at 11:50 AM during the dining observation, DS V moved a trash can, picked up several straws and sugar packets, and placed

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	175379	A. BUILDING _____ B. WING _____	C 09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505

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them on the room trays. She then picked up and looked through the resident's meal tickets, placed her hands on the countertop, placed tickets on the meal trays, grabbed a stack of plates, and opened the gate to the serving area without hand hygiene.

On 09/01/21 at 12:10 PM DS U pulled drinking glasses apart by holding the rim of the glasses before filling them with water and placed them on the tables for the residents.

On 09/01/21 at 12:19 PM DS U stated they were not to touch the rims of the drinking glasses when serving, and she was unaware that she touched the rim of the glasses during serving.

On 09/01/21 at 12:25 PM DS V revealed she would wash her hands once or twice during each meal service time. She stated she was unaware she moved a trash can and then proceeded to touch plates and attempt to serve.

On 09/07/21 at 10:43 AM during a follow up visit to the main kitchen DS T prepared plated and pureed cake. DS T used gloved hands to plate pieces of cake, she then touched the handle of the spatula that was left sitting on the counter top, the lid to the blender, placed her hands on the counter top, and then proceeded to continue to pick up pieces of cake to place in the blender and on the plates using the same gloved hands.

On 09/07/21 at 10:53 AM DS T stated she washed her hands just "a little while ago" but that she should probably have a plate or something on the countertop to place the used spatula and knife on.

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F 812	Continued From page 28 During an interview on 09/07/21 at 12:54 PM Certified Dietary Manager R expected all expired items be removed from use. She further stated that it was all staff responsibility to check expiration dates. DS R stated that all dishware should be stored inverted, and that she expected her staff to know this. Dietary Staff R stated that she also expected all her staff to know proper glove use and hand hygiene as the whole facility just had training on this subject, and that it was her responsibility to ensure her staff knew proper hand hygiene and glove use. DS R stated staff should not use gloved hands to touch any food items, they should always use a utensil and that utensil should be placed in the pan to which it was being used. The "Proper Hand Washing and Glove Use" policy dated 2020 documented that staff were to change gloves if they become contaminated by touching the face, hair, uniform, or other non-food contact surface, such as door handles and equipment. The facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by the failure of staff dispose of expired food items and to perform appropriate hand hygiene and use gloves appropriately.	F 812		
F 880 SS=D	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	F 880		

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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 least restrictive possible for the resident under the circumstances.

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(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 census totaled 77 residents with 20 residents included in the sample. Based on observation, interview, and record review the facility failed to ensure a sanitary environment by the failure of staff to change gloves and perform hand hygiene when going from dirty to clean areas, while changing the brief for one resident. Resident (R) 12.

Findings included:

- Observation on 09/07/21 at 10:25 AM revealed Certified Nurse Aide (CNA) G and CNA O toileting R12. CNA G pulled R12s pants down and removed his wet brief. CNA G removed R 12's pants due to being wet and a new clean pair placed on the resident along with a clean brief.

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CNA G then reached back to adjust the lift in the bathroom never changing her gloves from the wet brief. The resident was partially lifted to do peri care with wet wipes. CNA G performed peri care on the resident with gloved hands. She then pulled up and adjusted the clean brief and pants still wearing the gloves used for peri-care.

During an interview on 09/07/21 at10:30 AM CNA G reported she should have probably changed her gloves more than she did.

During an interview on 09/07/21 at 10:32 AM CNA O reported she would change her gloves after touching anything soiled and before going to clean..

During an interview on 09/08/21 at 12:20 PM Administrative Staff A reported all aides have received multiple trainings in the proper use of gloves and expected the staff member to know the correct way to use them.

The facility policy "Hand Hygiene" dated 05/21 revealed staff should wear gloves when it can be reasonably anticipated that contact with potentially infectious materials such as when a resident is incontinent of bowel or urine. The policy further noted staff should change gloves during resident care if the hands will move from a contaminated body site (perineal area) to a clean body-site.

The facility failed to ensure a sanitary environment for R12 by the failure of CNA staff to change gloves and perform hand hygiene during resident incontinent care.