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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 09/02/2020.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility had a census of 73 residents. The sample included 18 residents. Based on	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/02/2020

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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observation, record review, and interview, the facility failed to revise one of 18 care plans, Resident (R) 56's care plan for urinary catheter (tube placed in the bladder to drain urine into a collection bag).

Findings included:

- R56's "Physicians Order Sheet," dated 08/01/20, documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), benign prostatic hyperplasia/hypertrophy (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and bladder neck obstruction with retention of urine.

R56's "Annual Minimum Data Set" (MDS), dated 07/17/20, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS recorded the resident required limited assistance with bed mobility, independent with transfers, and required supervision with toilet use and personal hygiene. The MDS recorded the resident had an indwelling urinary catheter.

The "Urinary Incontinence/Catheter Care Area Assessment" (CAA), dated 07/24/20, documented the resident required a suprapubic (urinary bladder catheter inserted through the skin) urinary catheter, but lacked additional information.

The "Self-Care Deficit Care Plan," dated 07/30/20, directed staff to empty the suprapubic catheter every shift and as needed. The care plan

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lacked additional care for R56's catheter.

The "Physician Order," dated 07/02/19, documented the resident had a suprapubic catheter due to urinary retention.

The "Physician Order,"dated 08/06/20, directed staff to change the suprapubic catheter every four weeks, as needed, provide routine cares at the insertion site, and change the sponge daily, and as needed.

On 08/24/20 at 02:30 PM, observation revealed the resident ambulated with a walker from the living room to the therapy room and the urinary drainage tubing drug on the floor. Continued observation revealed the tubing attached to the urinary drainage bag clipped on the resident's walker.

On 08/25/20 at 08:30 AM, observation revealed the resident sat at the dining room table and ate breakfast with the urinary drainage tubing lying on the floor. Observation revealed the tubing attached to the catheter bag on the resident's walker.

On 08/26/20 at 10:30 AM, observation revealed the resident sat in a recliner with the urinary drainage tubing lying on the floor, hooked on the side of his walker, with cloudy yellow urine in the tubing.

On 08/26/2020 at 02:10 PM, Administrative Nurse E verified R56's care plan should be updated with interventions for care of the residents suprapubic catheter.

The facility's "Care Plan Development and

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F 657	Continued From page 3 Revision" policy, dated February 2020, documented a comprehensive plan of care would be developed by the interdisciplinary team and the resident in order to meet the resident's medical, nursing, mental, and psychosocial needs. Periodically, when the resident and their care needs change, the interdisciplinary team, using the results of periodic assessments, will further develop, review, and revise the comprehensive plan of care. The facility failed to update and revise R56's care plan to include appropriate suprapubic catheter care and treatment, placing the resident at risk for inadequate catheter care and potential urinary infections.	F 657		
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	F 690		

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as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 73 residents. The sample included 18 residents with one reviewed for urinary catheter (tube placed in the bladder to drain urine into a collection bag) use. Based on observation, record review, and interview, the facility failed to provide appropriate urinary catheter care for Resident (R) 56, who's urinary drainage tubing was on the floor three of four days during the survey.

Findings included:

- R56's "Physicians Order Sheet," dated 08/01/20, documented diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), benign prostatic hyperplasia/hypertrophy (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), and bladder neck obstruction with retention of urine.

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R56's "Annual Minimum Data Set" (MDS), dated 07/17/20, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS recorded the resident required limited assistance with bed mobility, independent with transfers, and required supervision with toilet use and personal hygiene. The MDS recorded the resident had an indwelling urinary catheter.

The "Urinary Incontinence/Catheter Care Area Assessment" (CAA), dated 07/24/20, documented the resident required a suprapubic (urinary bladder catheter inserted through the skin) urinary catheter but lacked additional information.

The "Self- Care Deficit Care Plan," dated 07/30/20, directed staff to empty the suprapubic catheter every shift and as needed. The care plan lacked additional care for R56's catheter.

The "Physician Order," dated 07/02/19, documented the resident had a suprapubic catheter due to urinary retention.

The "Physician Order," dated 08/06/20, directed staff to change the suprapubic catheter every four weeks, as needed, provide routine cares at the insertion site, and change the sponge daily, and as needed.

On 08/24/20 at 02:30 PM, observation revealed the resident ambulated with a walker from the living room to the therapy room and the urinary drainage tubing drug on the floor. Continued observation revealed the tubing attached to the urinary drainage bag clipped on the resident's

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walker.

On 08/25/20 at 08:30 AM, observation revealed the resident sat at the dining room table and ate breakfast with the urinary drainage tubing lying on the floor. Observation revealed the tubing attached to the catheter bag on the resident's walker.

On 08/26/20 at 10:30 AM, observation revealed the resident sat in a recliner with the urinary drainage tubing lying on the floor, hooked on the side of his walker, with cloudy yellow urine in the tubing.

On 08/26/20 at 01:10 PM, Administrative Nurse E verified the urinary catheter tubing lying on the floor and stated the tubing should be be kept off the floor.

The facility's "Catheter Care, Urinary" policy, dated September 2014, documented the purpose is to prevent catheter associated urinary tract infections. Maintaining unobstructed urine flow, check the resident frequently to be sure he/she is not lying on the catheter, and to keep the catheter and tubing free of kinks. The policy documented the urinary drainage bag must always be held or positioned lower than the bladder to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The policy documented to be sure to the tubing and drainage bag are kept off the floor, and ensure the catheter remains secured with a leg strap to reduce friction and movement at the insertion site.

The facility failed to provide R56 adequate urinary catheter care, placing the resident at risk for

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F 690	Continued From page 7 urinary infections.	F 690		
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 had a census of 73 residents. The sample included 18 residents with one reviewed for dialysis. Based on observation, interview, and record review, the facility failed to assess Resident (R) 9's dialysis access site twice daily as care planned. Findings included: - R9's "Physician Order Sheet" (POS), dated 07/21/20, documented a diagnosis of end stage renal disease (ESRD) requiring dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). The "Quarterly Minimum Data Set" (MDS), dated 05/06/20, documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented the resident required supervision with all activities of daily living (ADLs), reported rare, moderate pain, and received dialysis. The "Dialysis Care Plan," dated 08/20/20, documented the resident received dialysis three	F 698		

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times per week, and directed staff to monitor the resident's Arteriovenous (AV) shunt (abnormal connection between an artery and a vein, and is sometimes surgically created to help with dialysis treatment) for positive thrill (rumbling sensation that you can feel), and if no thrill noted, notify physician. The care plan directed staff to palpate (feel) the access site every shift, monitor for fluid overload (increased blood pressure, tachycardia, edema), monitor labs as ordered, and report abnormal lab values to the physician.

The "Progress Note," dated 08/17/20 at 12:03 PM, documented a nurse at the hospital called the facility stating the resident was in the Emergency Room (ER) due to her dialysis access site bleeding uncontrollably from dialysis. The hospital nurse stated the bleeding stopped, the site dressing was to stay in place today, and the facility nurse was to call for increased bleeding issues not improved with gentle pressure up to 20 minutes or brisk bleeding. The note documented the resident returned to the facility with a dressing in place and no noted bleeding at that time.

Review of R9's "Medical Administration Record" and "Treatment Administration Record" (MAR/TAR) lacked documentation of dialysis access checks.

On 08/26/20 at 11:15 AM, observation revealed R9 in her room with a clean bandage over her dialysis access site.

On 08/25/20 at 10:54 AM, R9 stated she received dialysis three days per week- Monday, Wednesday, and Friday. R9 stated the nurse checked her dialysis access when she returned from her appointment.

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F 698	Continued From page 9 On 08/26/20 at 04:02 PM, Licensed Nurse (LN) G stated the resident left the facility about 06:30 AM for dialysis on Monday, Wednesday, and Friday. LN G stated staff weighed the resident before dialysis and assessed the access site's thrill daily, but did not document any assessments. On 08/26/20 at 11:15 AM, Administrative Nurse D verified nurses were to check for thrill and bleeding each shift per the care plan and the facility had no documentation of the assessments. The facility's "Hemodialysis Access Care" policy, dated September 2010, directed staff to check the patency of the site at regular intervals, palpate the site to feel the thrill, and check for signs of infection at the access site when performing routine care and at regular intervals. The facility failed to assess R9's dialysis access site routinely at regular intervals, placing the resident at risk for dialysis access problems.	F 698		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: The facility had a census of 73 residents. Based on record review and interview, the facility failed	F 730		

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to ensure every Certified Nurse Aide (CNA) employed at the facility for at least one year completed the minimum 12 hours of in-services per year and lacked a system for accurately tracking nurse aide education.

Findings included:

- The facility's employment records documented 18 nurse aides were employed at the facility for at least one year. The facility's in-service records lacked documentation that all 18 nurse aides completed the required 12 hours of in-service training in the past year and lacked a tracking system.

On 08/27/20 at 09:30 AM, Administrative Staff A stated the facility lacked a system in place to monitor completion of in-service hours and acknowledged the 18 aides lacked the 12 hours of yearly in-service.

The "Staff Education and In-Services" policy, dated August 2020, documented the facility would provide regular, planned education for all staff. The purpose of such on-going education is to ensure that facility services and procedures assist residents to attain and maintain their highest practicable level of physical, mental, and psychosocial functioning. The direct care staff shall participate in at least 12 hours of in-service education each year. The in-service program shall provide all employees with training in at least the following areas; fire prevention and safety, disaster preparedness, accident prevention; resident rights, psychosocial needs of residents, dementia care; infection prevention and control; prevention of abuse, neglect, exploitation , crime and reporting of suspicion of

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F 730	Continued From page 11 such; and suicide prevention. The policy documented the facility shall maintain documentation of in-services; content outline, presenter, and individual staff attendance record. The facility failed to ensure every CNA employed at the facility for at least one year completed a minimum 12 hours of in-services per year and lacked an accurate tracking system, placing the residents at risk for inappropriate care.	F 730		
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,	F 880		

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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.
(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.

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F 880	Continued From page 13 This REQUIREMENT is not met as evidenced by: The facility had a census of 73 residents. Based on observation, interview, and record review, the facility failed to implement infection control procedures to disinfect the glucometer (instrument used to calculate blood glucose [sugar]), disinfect contaminated laundry, and to dispose of potentially infectious face masks inside the droplet isolation room, in one of two facility buildings. (Resident (R) 9, R44, R66) Findings include: - On 08/25/20 at 03:14 PM, Social Services (SS) X donned gown, gloves, and wore a cloth face mask. SS X entered the droplet precaution room to see R66 who was in quarantine due to his new admission to the facility. Later SS X came out of the room wearing the face mask, removed her gloves, and used hand gel. Observation revealed SS X kept the cloth face mask on while standing by the isolation room and a staff person brought her a disposable face mask. On 08/25/20 at 03:14 PM, SS X verified she should have removed the gloves and face mask prior to leaving the isolation room. The facility's "Isolation Precautions" policy, dated October 2018, documented gloves and disposable gowns will be removed before leaving the room. The facility failed to follow infection control guidelines when staff failed to remove a soiled mask after leaving R66's room (while in quarantine), placing the residents at risk for infection.	F 880		

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	175350	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE PLACE	1100 N 16TH MARYSVILLE, KS 66508

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F 880	Continued From page 14	F 880		

- On 08/26/20 at 07:11 AM, observation revealed Licensed Nurse (LN) G used a glucometer to obtain R44's blood sugar, then used Lysol spray (a brand name of cleaning and disinfecting spray not effective on blood borne pathogens) to disinfect the glucometer and let it lie on a clean paper towel. Further observation revealed LN G, using the same glucometer, obtained R66's blood sugar sample and used Lysol spray to disinfect the glucometer.

On 08/26/20 at 07:13 AM, LN G stated the facility ran out of Micro-Kill (disinfectant) wipes, so they used Lysol and changed the facility policy to Lysol for cleaning the glucometer. She verified staff used the glucometer to test nine residents' blood sugar.

On 08/27/20 at 11:28 AM, Administrative Nurse D stated the facility could not obtain bleach wipes and started using the Lysol spray to disinfect the glucometer. Administrative Nurse D verified Lysol did not kill blood borne pathogens (microorganisms such as viruses or bacteria that are carried in blood and can cause disease in people).

The glucometer's manufacturer's "Instructions for Disinfection" instructed staff to use Environmental Protection Agency (EPA) approved bleach wipes or Micro-Kill alcohol wipes and leave the disinfectant wet on the glucometer for a specific time.

The facility failed to properly disinfect a multiuse glucometer between resident uses, placing the residents at risk for infection.

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F 880	Continued From page 15	F 880		

- On 08/26/20 at 08:56 AM, observation of the laundry process revealed staff used Prestige laundry products and Pure Build detergent which was hooked up to the facility washing machines.

The "June, July, and August 2020 Water Temperature Logs" documented daily temperatures between 128-138 degrees Fahrenheit (F).

On 08/26/20 at 09:02 AM, Laundry Staff (LS) V stated she only used bleach on whites and linens, no clothing. LS V stated she had been told to wash quarantined resident laundry together with regular laundry. LS V stated if the resident was positive for COVID 19, she would wash their laundry separately. She stated the gowns staff wore in the quarantine room were washed separately. LS V stated she had not been trained to wear gowns during laundry and just wore a cloth face mask and gloves. LS V stated she should wash quarantine laundry separately.

On 08/26/20 at 09:10 AM, Housekeeping/Laundry Staff U stated the facility used Pure Build products since last fall, used bleach for certain cycles - linens, whites, and washed resident's clothing all together.

On 08/27/20 at 02:33 PM, Housekeeping/Laundry Staff U verified the Pure Build detergent lacked disinfectant qualities.

On 08/27/20 at 11:26 AM, Administrative Nurse D verified staff did not disinfect residents' laundry properly due to no regular use of disinfectant and no record of disinfectant use.

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F 880	Continued From page 16 The facility undated "Laundry Temperatures" policy posted in laundry, documented water temperatures to be 120-170 F, and if below 160 F, 125 ppm (parts per million) disinfectant added. The facility failed to properly disinfect residents' laundry when staff washed all residents' laundry together, placing the residents in one of two facility buildings at risk for potential infections when staff did not separate and properly disinfect laundry.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F 883		

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F 883	Continued From page 17	F 883		

immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 73 residents. The sample include 18 residents with 10 reviewed for immunizations. Based on record review and interview, the facility failed to provide five of 10 sampled residents, Resident (R) 21, R23, R30, R43, R51, in one of two facilities, with the current Centers for Disease Control and Prevention (CDC) pneumococcal and influenza vaccine

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F 883	Continued From page 18	F 883		

information to make an informed decision.

Findings included:

- On 08/26/20 at 10:38 AM, review of R21, R23, R30, R43, and R51's immunization records documented the use of the CDC's "Inactive Influenza Vaccine, What You Need to Know Vaccine Information Statement," dated 06/03/06, but lacked the current fact sheet dated 08/15/19, and the "Pneumococcal Polysaccharide Vaccine Information statement," dated 07/29/97, but lacked the current fact sheet dated 10/30/2019.

On 08/26/20 at 10:38 AM, Administrative Staff A verified the facility did not provide the residents or their representatives, in one of two facilities, with the current CDC information for the administration of influenza and pneumococcal immunizations.

The facility's "Influenza Vaccination" policy and "Pneumococcal Vaccination" policy, dated March 2020, lacked direction to ensure the resident or their representative were given the current CDC information.

The facility failed to provide R21, R23, R30, R43, R51, or their representatives, with current CDC influenza and pneumococcal immunization information, placing the residents at risk for making uninformed decisions.