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	17E591	A. BUILDING _____ B. WING _____	02/17/2020

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VALLEY HEALTH CARE CENTER	400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00147170. The 2567 was electronically sent to the facility on 02/19/2020	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications.	F 636		

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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(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 31 residents. The sample included 11 residents. Based on record review, observation and interview, the facility failed to complete an annual comprehensive assessment, which included the "Minimum Data Set" (MDS) and "Care Area Assessment"(CAA), within the required "Resident Assessment Instrument" (RAI-the instructive

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guide for completion of the MDS) manual timeframe of 14 days for one Resident (R)23.

Findings included:

- The "Electronic Medical Record" (EMR) for R23 documented under the "Diagnoses" tab diagnoses of: paranoid schizophrenia (a mental illness characterized by hearing voices and believing everyone is out to cause or suffer harm), major depressive disorder (a mood disorder), dementia (a progressive mental disorder characterized by failing memory and confusion), and type II diabetes mellitus (the body's inability to produce enough insulin, or it resists insulin).

Review of R23's "MDS" revealed an "Assessment Reference Date" (ARD) of 12/23/19. The MDS completion date was 01/08/20, which was completed two days after the required 14 days as directed in the RAI manual. The MDS for R23 documented triggered CAAs for nutritional status, psychotropic drug use, and return to the community referral.

"Section V" of the MDS documented a completion date of 01/09/20, which indicated the CAAs were completed three days after the required 14 days as directed in the RAI manual.

On 02/17/20 at 12:16 PM Administrative Nurse E stated she completed certain parts of the MDS usually within 10-14 days of the ARD date. The facility switched to a new computer system and she had not completed Section GG, of the MDS for a few residents which caused the MDS and CAAs to be completed late. The MDS assessments were given to the Director of

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F 636	Continued From page 3 Nursing (DON) for finalization. On 02/17/20 at 12:18 PM Administrative Nurse D stated she was responsible for finalization of the MDSs after they are completed by the MDS coordinator. MDSs and CAAs are typically completed within the required 14 days as directed in the RAI manual. The facility recently changed computer systems for their medical records and a few MDSs/CAAs were not completed on time. The facility's policy for "Minimum Data Set (MDS)" revised on November 28, 2017 documented: The data gathered may be done by a licensed nurse or other member of the interdisciplinary team and reviewed by a "Registered Nurse" for completion. The facility staff followed the current RAI manual for proper procedures for completion of the MDS. The facility failed to follow the RAI manual guidelines for timely completion of R23's MDS and CAAs.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility identified 31 residents. The sample included 11 residents. Based on observations, record reviews, and interviews the facility failed to accurately document the presence of an indwelling Foley catheter (a flexible plastic tube inserted into the bladder that remains there to provide continuous urinary drainage) on Resident	F 641		

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(R) 5's admission "Minimum Data Set" (MDS) assessment.

Findings included:

-The "Diagnoses" tab of R5's "Electronic Medical Record" (EMR) documented diagnoses of unspecified hydronephrosis (abnormal enlargement or swelling of a kidney due to dilation of the kidney calices and the kidney pelvis), and other obstructive and reflux uropathy (when urine cannot flow through your ureter, bladder, or urethra due to some type of obstruction and instead flows backward into your kidneys).

The "MDS" dated 06/10/19 revealed the resident was independent with "Activities of Daily Living" (ADLs) with supervision for dressing and toilet use. The MDS recorded R5 was continent of urine with no appliances.

The "MDS" dated 11/18/19 revealed the resident was independent with her ADLs but required supervision with her personal hygiene and toileting. R5 had an indwelling catheter.

The "ADL" "Care Area Assessment" (CAA) dated 06/13/19 revealed the facility staff emptied R5's catheter bag.

The "Catheter Care" care plan dated 06/13/19 documented R5 had urinary retention (difficulty urinating and completely emptying the bladder) secondary to obstructive uropathy and staff monitored for signs of urinary tract infection (an infection in any part of the urinary system, the kidneys, bladder, or urethra), changed her catheter monthly or as needed, and performed

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catheter care every shift.

The "Physician's Order" tab of R5's EMR documented an order for an indwelling Foley catheter with directions for monthly catheter change, output monitoring, routine catheter care and as needed (PRN) insertion, dated 06/03/19

The "Progress Notes" tab of R5's EMR revealed a nurse note by Licensed Nurse H on 06/03/19 at 01:40 PM which documented R5 arrived at facility with a patent indwelling catheter.

On 02/17/20 at 12:16 PM Administrative Nurse E stated a Foley catheter would be included in an admission MDS.

On 02/17/19 at 12:36 PM Licensed Nurse G stated the aides did catheter care, bags were changed once a week, and R5 wore a leg bag.

On 02/17/20 10:09 AM R5 walked with the surveyor to her room and invited the surveyor in. R5 stated the staff cleaned the catheter area twice a day.

The "MDS" policy dated 11/28/17 stated the facility conducted a comprehensive MDS according to Federal regulations and Medicare guidelines. The policy set guidelines as the data gathering was done by a licensed nurse or other member of the interdisciplinary team and reviewed by a Registered Nurse for completion. The facility staff followed the current Resident Assessment Instrument (RAI- guide for proper procedures on completing the MDS) manual.

The facility failed to accurately complete the admission MDS to reflect R5's indwelling Foley

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F 641	Continued From page 6 catheter.	F 641		
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 identified a census of 31 residents. The sample included 11 residents. Based on record reviews, observations, and interviews, the facility failed to revise the comprehensive care plan to include an intervention for the prevention	F 657		

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of further falls for one Resident (R)13 of five residents sampled for accidents.

Findings included:

- The "Diagnoses" tab of R13's "Electronic Medical Record" (EMR) documented diagnoses of schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), impulsiveness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), extrapyramidal movement disorder (movement disorders as a result of taking certain medications), and psychosis (any major mental disorder characterized by a gross impairment).

The "Minimum Data Set" (MDS) dated 10/08/19 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. He was independent with his "Activities of Daily Living" (ADLs). He had no falls since the last assessment.

The " MDS" dated 12/30/19 documented a BIMS score of 14. He was independent with his ADLs. He had no falls in the look back period.

The "Falls" "Care Area Assessment" (CAA) dated 10/09/19 documented R13 was alert and able to communicate his needs. He was at risk for falls due to his independence in walking, poor safety awareness, and psychotropic medication (medications used to treat psychosis) use.

The "Falls" care plan dated 11/14/19 documented the Consultant Pharmacist reviewed R13's

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medications which could cause dizziness, weakness or unsteady gait. The facility staff completed fall risk assessments quarterly. The staff checked R13's blood pressure if he felt unsteady and kept his call light within his reach. The staff also ensured he wore non-skid socks or shoes when ambulating. The care plan lacked intervention after he fell on 01/25/20.

The "Fall Risk Assessments" under the assessments tab of the EMR dated 10/02/19 and 12/27/19 documented R13 had a steady gait and ambulated on his own. No falls were noted in the previous 90 days in either assessment.

A "Nursing Progress Note", in R13's EMR, dated 01/25/20 documented R13 sustained a head injury with an unwitnessed fall on 01/25/20.

The fall investigation dated 01/25/20 documented R13 came inside the facility covered in mud. Vital signs were obtained. He had sustained an abrasion to his left cheek and a minor scratch to the corner of his right eye. He was alert and awake. He denied pain and had full range of motion to his extremities. No root cause analysis of the fall was documented. An intervention to prevent future falls was not documented.

On 02/13/20 at 11:56 AM R13 walked from his room to the dining room with a steady gait. He mumbled a response to a staff member who spoke to him.

On 02/17/20 at 11:08 AM Certified Nurse Aide M stated he was not sure how R13's fall occurred. Some of the residents fall due to their behaviors at the time of the fall. He notified the nurse when residents fell and only moved them if he was told

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F 657	Continued From page 9 it was all right to do so. On 02/17/20 at 11:15 AM Licensed Nurse G stated when she was notified of a resident's fall, she did full body assessments and notified the Director of Nursing (DON), physician, and next of kin. The nurses obtained witness statements and completed the evaluation forms. The DON completed the analysis for the root cause and placed an intervention for prevention of future falls into the care plan. The nurses could place an intervention when the DON was not in the facility at the time of the fall. Care plans are reviewed by the MDS Coordinator as a rule. On 02/17/20 at 11:39 AM Administrative Nurse D stated the administrative staff reviewed the camera feeds but, did not see R13's fall occur. R13 told the staff he had tripped and fallen in the mud. There was no root cause analysis or intervention done on the fall. Care plans are reviewed/revised by the administrative team. The facility's "Care Plan" policy dated 11/28/17 documented the comprehensive care plan reflected individualized problems, goals, and interventions based on the resident's preferences and wishes. The are developed after completion of the MDS and CAAs with input from the care planning team, the resident and the resident's family and/or representative. The facility failed to revise the comprehensive care plan to reflect an intervention to prevent future falls for R13. This had the potential for future falls and possible injury to the resident.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 31 residents. The sample included 11 residents. Based on record reviews, observations, and interviews, the facility failed to identify the root cause for a fall and implement an appropriate intervention for the prevention of further falls for one Resident (R)13 of five residents sampled for accidents.

Findings included:

- The "Diagnoses" tab of R13's "Electronic Medical Record" (EMR) documented diagnoses of schizoaffective disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), impulsiveness, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), extrapyramidal movement disorder (movement disorders as a result of taking certain medications), and psychosis (any major mental disorder characterized by a gross impairment).

The admission "Minimum Data Set" (MDS) dated 10/08/19 documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. He was independent with his "Activities

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of Daily Living" (ADLs). He had no falls since the last assessment.

The quarterly" MDS" dated 12/30/19 documented a BIMS score of 14. He was independent with his ADLs. He had no falls in the look back period.

The "Falls" "Care Area Assessment" (CAA) dated 10/09/19 documented R13 was alert and able to communicate his needs. He was at risk for falls due to his independence in walking, poor safety awareness, and psychotropic medication (medications used to treat psychosis) use.

The "Falls" care plan dated 11/14/19 documented the Consultant Pharmacist reviewed R13's medications which could cause dizziness, weakness or unsteady gait. The facility staff completed fall risk assessments quarterly. The staff checked R13's blood pressure if he felt unsteady and kept his call light within his reach. The staff also ensured he wore non-skid socks or shoes when ambulating.

The fall risk assessments dated 10/02/19 and 12/27/19 documented R13 had a steady gait and ambulated on his own. No falls were noted in the previous 90 days in either assessment.

A nursing progress note, in R13's EMR, dated 01/25/20 documented R13 sustained a head injury with an unwitnessed fall on 01/25/20.

The fall investigation dated 01/25/20 documented R13 came inside the facility covered in mud. Vital signs were obtained. He had sustained an abrasion to his left cheek and a minor scratch to the corner of his right eye. He was alert and awake. He denied pain and had full range of

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motion to his extremities. No root cause analysis of the fall was documented. An intervention to prevent future falls was not documented.

On 02/13/20 at 11:56 AM R13 walked from his room to the dining room with a steady gait. He mumbled a response to a staff member who spoke to him.

On 02/17/20 at 11:08 AM Certified Nurse Aide M stated he was not sure how R13's fall occurred. Some of the residents fall due to their behaviors at the time of the fall. He notified the nurse when residents fell and only moved them if he was told it was all right to do so.

On 02/17/20 at 11:15 AM Licensed Nurse G stated when she was notified of a resident's fall, she did full body assessments and notified the Director of Nursing (DON), physician, and next of kin. The nurses obtained witness statements and completed the evaluation forms. The DON completed the analysis for the root cause and placed an intervention for prevention of future falls into the care plan. The nurses could place an intervention when the DON was not in the facility at the time of the fall.

On 02/17/20 at 11:39 AM Administrative Nurse D stated the administrative staff reviewed the camera feeds but, did not see R13's fall occur. R13 told the staff he had tripped and fallen in the mud. There was no root cause analysis or intervention done on the fall.

The facility "Occurrences" policy dated 11/28/17 documented any accident or occurrence was thoroughly investigated to rule out abuse and neglect and to determine a root cause.

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F 689	Continued From page 13 Appropriate interventions were developed based on the root cause analysis. The facility failed to complete a root cause analysis or place an intervention to prevent future falls for R13. This had the potential for future falls and possible injury to the resident.	F 689		
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 identified a census of 31 residents. The facility had one main kitchen. Based on observation and interview, the facility failed to label, date and monitor stored foods, which included opened packages of frozen prepared meats, so foods are used by their use-by date, are frozen, or discarded.	F 812		

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	17E591	A. BUILDING _____ B. WING _____	02/17/2020

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F 812	Continued From page 14 Findings included: - During the initial tour of the facility freezers on 02/11/20 at 08:29 AM, observation revealed the following items stored in the freezers were not labeled or dated: In freezer two, there were eight frozen sausage links in a zip-lock plastic bag with no label or expiration date on it. In freezer three, there was one frozen breaded patty of meat in its original package opened and not dated or labeled. During an interview on 02/17/20 at 10:40 AM Dietary staff BB stated her staff usually did a good job of labeling and dating all items stored in refrigerators and freezers. The staff should label and date all items as they are used and put them in new labeled and dated storage containers for later use. The facility policy "Food Storage" revised on 06/08/12 documented the facility stored leftover contents of can and prepared foods in clean, sanitized containers with proper and secured covers. The new container was labeled with the name of the food item and the original expiration date. The facility failed to ensure a frozen breaded meat patty and sausage links were placed and stored in new packages and properly labeled and dated with original expiration date. This deficient practice had the potential of causing a food borne illness to all 31 residents of the facility.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

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F 880	Continued From page 15 §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; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 16	F 880		

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 identified a census of 31 residents. The sample included 11 residents. Based on observations, record reviews, and interviews the facility failed to ensure the use of standard infection control precautions (infection prevention practices which include but are not limited to hand hygiene and use of gloves) while performing blood glucose (blood sugar levels) monitoring and the administration of insulin (medication used to treat diabetes mellitus-when the body can't use glucose, not enough insulin made or the body can't respond to the insulin) for two Residents

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(R)18 and R19.

Findings included:

- On 02/13/20 at 04:00 PM Licensed Nurse H sanitized his hands, donned gloves, and placed a glucometer (device used to measure blood sugar levels) on his computer keyboard. He took a pen and keys out of his pocket and placed them on the medication cart. He retrieved an insulin pen out of the medication cart. He obtained the blood sugar reading and administered insulin to R18, placed the glucometer and insulin pen on the computer keyboard, disposed of the lancet (needled instrument used to prick the skin to obtain blood sample), and typed on the computer. He did not sanitize the insulin pen and replaced it in the medication cart. He took his gloves off and sanitized his hands and donned another pair of gloves. He did not sanitize the glucometer. He wiped R19's finger off with an alcohol wipe, used the lancet to obtain a blood sample and used the same glucometer to obtain a blood sugar reading. He placed the glucometer on the medication cart and obtained an insulin pen out of the medication cart. He administered R19's insulin and disposed of the lancet. He placed the glucometer on the computer board. He did not sanitize the insulin pen and placed it in the medication cart. He took off his gloves and sanitized his hands but did not sanitize the glucometer while he waited for residents from the residential care side of the facility to have their blood sugars checked.

On 02/17/20 at 02:22 PM Licensed Staff G stated staff sanitized hands before and after resident cares and sanitized equipment used during cares after each use. The facility provided glucometers for residents who required frequent blood sugar

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readings.

On 02/17/20 at 02:20 PM Administrative Nurse D stated she expected the facility staff to sanitize their hands before and after procedures and to sanitize equipment used during cares after each use. The facility provided separate glucometers for each resident.

The facility's "Glucose Monitoring" policy dated 11/28/17 documented all residents had their own glucometer. The equipment was placed on a clean surface covered by a towel or paper towel. The glucometer was cleaned and returned to a plastic bag before it was stored. Multiple use glucometers were cleaned with a disinfectant maintaining recommended wet times after each use.

The facility's "Hand Washing" policy dated 11/28/17 documented staff cleansed hands with an alcohol-based hand rub before and after contact with the residents, after contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the residents' environment.

The facility failed to use proper hand washing techniques when obtaining blood sugar levels and the administration of medications. These had the potential of increasing the risk for spread of infections to the residents, staff and people they associate with outside of the facility.