STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175555	A. BUILDING _____ B. WING _____	11/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF TOPEKA	6300 SW 6TH AVENUE TOPEKA, KS 66615

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00141823, #KS00142689, and #KS00146754. 2567 was electronically sent to the facility on 11/07/19	F 000		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		

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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The facility reported a census of 69 residents. The sample included one medication room and five medication carts. Based on observation, record review, and interview, the facility failed to properly label and store three medication inhalers in one of five medication carts.

Findings included:

- On 10/31/19 at 11:43 AM the medication aide cart on the west side of the facility contained the following inhalers (medications used to treat breathing difficulties):

Two Symbicort (medication used to treat breathing difficulties) inhalers, opened and undated;
One Ventolin (medication used to treat breathing difficulties) inhaler, opened and undated.

A review of the manufacturer's instructions for the Ventolin inhaler noted that the inhaler has a counter attached to the canister. The counter starts at 204 or 64 and counts down each time a spray is released. The correct amount of medication in each actuation cannot be assured after the counter reads 000, even though the canister is not completely empty and will continue to operate. The inhaler should be discarded when the counter reads 000 or 12 months after removal from the moisture-protective foil pouch, whichever comes first.

A review of the manufacturer's instructions for the Symbicort inhaler noted that the inhaler should be discarded when the labeled number of inhalations have been used, or within 3 months after removal from the foil pouch.

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F 761	Continued From page 2 On 10/31/19 at 11:43 AM Licensed Nurse (LN) H stated that three inhalers in the medication aide cart on the west side of the facility should be labeled with an open date and verified they were not. On 11/06/19 at 02:25 PM Administrative Nurse D stated that she expected nurses to date the inhalers when they were opened. The facility's policy "Storage of Medications" revised 4/2007, lacked documentation for the storage and labeling of opened respiratory inhalers. The facility failed to properly label and store three medication inhalers in one of five medication carts, which placed the residents at risk for adverse consequences or ineffective treatment.	F 761		
F 812 SS=E	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.	F 812		

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F 812	Continued From page 3 §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 had a census of 69 Residents. The facility had one main kitchen, and two satellite kitchenette serving areas. Based on observation and interview, the facility failed to ensure safe and sanitary delivery of food for residents who resided on the west wing of the facility. Findings included: - During observation of the facility's west wing remote kitchen meal service on 11/05/19 at 11:54 Dietary CC failed to change gloves on multiple occasions after handling dinner rolls. She would open drawers or cabinets to obtain more bowls or dishes, then return to serving food with the same gloves on. While checking the temperature for a bowl of soup, the string of the thermometer fell into the pan of chicken and dumplings, and touched food on a plate that was ready to be served. During interview of Dietary CC on 11/05/19 at 12:30 PM, she stated "Oh yes, we have tongs. I probably should have used them. I have been doing this for a long time, and it is a silly mistake." During interview of Dietary Manager on 11/06/19 at 01:08 PM he stated, "We have food service training upon hire, and we have a daily meeting amongst dietary staff to go over proper handling and serving techniques." He further stated, "the tongs for the west wing on that day were still here in the kitchen as they had just been put through the dishwasher."	F 812		

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F 812	Continued From page 4 The facility policy "Infection Control Policy/Procedure", revised 05/2019, documented: It is the policy of this facility to prevent contamination of food products and therefore prevent foodborne illness. Washing hands carefully with soap and water whenever they become soiled; before touching food, clean dishes and silverware. It further stated, utensils, cups, glasses and dishes must be handled in a way as to avoid touching surfaces with food or drink will come in contact. Tongs must be used when serving rolls, pickles, etc. The facility failed to follow the sanitary procedures and/or adhere to infection control practices when staff failed to change gloves after touching non-food surfaces before touching food with same gloves on. The facility also failed to use proper utensils to serve residents placing the residents at risk for food borne illnesses.	F 812		
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:	F 880		

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F 880	Continued From page 5 §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. (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	F 880		

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F 880	Continued From page 6	F 880		

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 69 residents. The sample included 19 residents. Based on observations, record reviews, and interviews the facility failed to utilize accepted standard universal precautions (infection prevention practices which include but are not limited to hand hygiene and use of gloves) while performing a bathroom cleaning in room 117, which was under isolation precautions (precautions to help reduce the spread of infections throughout the facility) due to Clostridium Difficile (a bacterium that causes symptoms ranging from diarrhea to life-threatening inflammation of the colon) and failed to ensure sanitary wound dressing changes for Resident (R) 26.

Findings included:

- On 11/05/19 at 09:50 AM Housekeeping Staff (HS) U donned a pair of gloves and proceeded to spray the bathroom sink, shower, and toilet with Clorox disinfectant (used to kill bacteria/germs). She went outside the room to place the Clorox in the housekeeping storage cart. She returned to the bathroom to wipe down the fixtures with clean rags and placed the soiled rags in a plastic bag.

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She returned to the housekeeping storage cart to retrieve more clean rags and returned to finish wiping down fixtures. She did not remove the gloves or wash her hands with either trip to the housekeeping storage cart, nor did she wash or sanitize her hands after finishing the procedure and proceeding down the hall.

On 11/05/19 at 10:20 AM HS U stated she did not realize the lack of hand washing or need for changing gloves each time she left the room.

On 11/06/19 at 02:25 PM Administrative Nurse D stated she expected staff to wash their hands after taking care of soiled items and going in and out of isolation rooms.

The facility's "Hand Washing" policy dated July 2014 documented hand washing/hand hygiene is generally considered the most important single procedure for preventing the transmission of infection. For specific handwashing and waterless hand hygiene procedures, the facility refers to the Center for Disease Control's (CDC's) most current guidelines.

The CDC's current handwashing guidelines, at https://www.cdc.gov/longtermcare, documented handwashing is done, when hands are visibly dirty or contaminated with blood or other fluids, with an antimicrobial soap and water. Decontaminate hands before having direct contact with patients, contact with body fluids or excretions, after contact with inanimate objects, and after removing gloves.

The facility failed to use standard infection control precautions for hand washing, which had the potential of spreading an infectious disease to the

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F 880	Continued From page 8 residents and staff. - On 11/05/19 at 07:41 AM Licensed Nurse (LN) G, performed a wound dressing change for R26. LN G knocked, entered room, asked R26 for permission for surveyors to observe. LN G washed her hands, she then placed two blue chux (disposable sheets with an absorbent top layer and waterproof backing) pads on floor. LN G sat on floor and prepared supplies and placed them on chux pads. R26's right leg was wrapped with Kerlix gauze (woven gauze used for dressings). LN G with gloves on, cut off old dressing and placed it in the trash can beside her, sprayed open wounds with Skin Tegrity (wound cleanser) and patted with 2x2 gauze. LN G removed gloves and left room to obtain a wound measuring tape. Upon returning to room LN G washed her hands and reapplied gloves to measure right medial ankle wound and right calf wound. LN G cleaned the scissors with alcohol wipe and cut Puracol collagen (a wound treatment dressing that converts to a soft gel sheet that stays in contact with wound bed as it absorbs exudate (fluid drainage)) to fit open wounds, covered with absorbent pads and Kerlix wrap. LN G then applied Tubigrip (tubular bandage) to both legs. While cleaning up the supplies, LN G sat the package of 2x2 gauze directly on the floor by the recliner and sat the bottle of wound cleanser directly on the floor. LN G then took the supplies back to the treatment cart and put the 2x2's and wound cleanser in the cart after being on the floor. On interview with LN G on 11/05/19 at 08:17 AM stated, "I wasn't aware that I placed those items on the floor and that it is not my usual practice."	F 880		

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On interview with Administrative Nurse D on 11/06/19 at 02:18 PM stated, "Competency and skills tests are done upon hire and yearly. The Nurse Practitioner and LN G do wound assessments together and LN G does all the wound care dressing changes in the facility. And she would expect that proper clean dressing techniques be used at all times."

The facility's policy "Licensed Nurse Procedures: Wound Care", revised 05/2018 documented: Procedure for Clean Dressing Technique: Wash hands prior to handling clean contents of treatment cart; take treatment cart to the resident's room, but not in contact with the resident or belongings. Gather and set up supplies in the resident area- establish clean field not on the treatment cart; open supplies onto clean field, including several clean gloves; prepare ointments and medications. Wash hands and apply clean gloves. Remove old dressing, and discard in the appropriate disposal bag. Remove gloves, wash hands and reapply clean gloves. Cleanse wound with solution ordered. Do not directly touch any item that will come into direct contact with wound. Remove gloves, wash hands, and apply clean gloves. Apply any medication ordered and dress wound. Discard soiled materials in plastic bag. Remove gloves and wash hands.

The facility failed to use standard infection control precautions for wound care for R26, which had the potential of spreading infectious diseases to residents and staff.