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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation KS00144156. The 2567 was electronically sent to the facility on 08/08/19.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		

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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This REQUIREMENT is not met as evidenced by:
The facility reported a census of 37 residents with 13 residents included in the sample. Based on observation, interview, and record review the facility failed to ensure staff immediately identified and reported allegations of abuse, neglect, exploitation or mistreatment immediately to the administrator of the facility as per facility policy and regulatory requirements for Resident (R) 9.

Findings included:

- During a confidential interview on survey, a staff member stated two to three weeks ago R9 told him/her of an allegation of abuse against Certified Nurse Aid (CNA) Q from 2 years ago and R9 reported she did not like CNA Q. The unidentified staff member assumed it had been dealt with, due to the age of the incident. The unidentified staff member said he/she knew to go to administrative staff with allegations of abuse, neglect and exploitation (ANE) but said he/she froze and did not know what to say but informed a licensed nurse. The unidentified staff member said when R9 told him/her of the abuse allegation R9 asked him/her to take her back to her room a different way to avoid CNA Q. The unidentified staff said no other residents had complaints about CNA Q.

Interview during the resident council meeting on 07/31/19 at 10:00 AM revealed after the surveyor asked if any staff had made the residents feel afraid, humiliated, or degraded, R25 said R9 did not like CNA Q. R9 stated she did not want to talk about it at that time.

Interview with R9 on 08/01/19 at 11:12 AM

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revealed an allegation of ANE involving CNA Q from 2017. R9 said she had "reported to everyone that I do not care for him." R9 said she figured if she stayed away from CNA Q, "I would not have to worry about it, but I wonder if he has hurt anyone else." Further interview with R9 revealed she was not fearful of CNA Q but did not care for him.

Interview with CNA U on 08/05/19 at 03:00 PM revealed she knew R9 did not like CNA Q and everyone knew that because R9 told everyone she saw. CNA U said R9 had never told her why she did not like CNA Q, and R9 was never really willing/would talk about it. CNA U said the resident never displayed fear of CNA Q.

Interview with CNA M on 08/05/19 at 03:05 PM revealed R9 had always said she did not like CNA Q, but CNA M did not ask R9 for the reason.

Interview with Certified Medication Aide (CMA) R on 08/05/19 at 03:12 PM revealed she asked the resident why she rearranged her room and R9 said she was tired of seeing CNA Q walk up and down the hallway. CMA R said R9 said it jokingly and said a lot of residents did not like CNA Q.

Interview with Licensed Nurse (LN) H on 08/01/19 at 11:56 AM revealed she received a report R9 had a dislike for CNA Q, but stated no other details were relayed to her, and she did not report it further. LN G said R9 had never really said why she did not like CNA Q and said no other residents had voiced a concern regarding CNA Q.

Interview with Administrative Staff B on 08/01/19 at 11:30 AM revealed the facility had not had any complaints against CNA Q in the last five years.

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F 609	Continued From page 3 Interview with Administrative Staff A on 08/01/19 at 02:27 PM revealed the facility suspended CNA Q. Administrative Staff A revealed CNA Q had worked at the facility since 2006 with no investigations in his file. Administrative Staff A revealed upon notification of the ANE allegation today, the facility had appropriately reported the ANE allegation. Review of the policy and procedure for abuse, neglect, and exploitation (ANE), date unknown, revealed ANE would be covered in employee training and through ongoing yearly in-services. The training would reflect on what constitutes ANE, the detection of, interventions for, reporting of, prevention of to include reasonable suspicion of a crime against a resident. All employees would complete a mandatory in-service quiz upon completion of the review of the facility policy. Immediate reaction was expected of all staff to all allegations or questions of ANE by residents, family members, employees or guests. Staff were to immediately protect the resident and report to the person in charge or up the chain of command. The facility failed to ensure staff immediately identified and reported allegations of abuse, neglect, exploitation or mistreatment immediately to the administrator of the facility as per facility policy and regulatory requirements for Resident (R) 9.	F 609		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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F 689	Continued From page 4 §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 reported a census of 37 residents with eight cognitively impaired, mobile residents noted. Based on observation and interview the facility failed to provide an environment free from accident hazards over which the facility had control when the facility staff left poisonous chemicals in an unlocked cabinet to which residents had access. Findings included: - Observation on 07/31/19 at 05:28 PM revealed an unlocked shower room door on the 200 hallway with a chemical noted in an unlocked cabinet. The chemical was noted as "73 Acid" bathroom cleaner and a label which noted the chemical as poisonous. Interview with Certified Nurse Aide (CNA) Q on 07/31/19 at 05:30 PM revealed the shower room doors should be locked and the chemicals should not be in unlocked cabinets. Interview with Administrative staff A on 07/31/19 at 07:02 PM revealed the shower room doors should be locked. The facility failed to provide a policy regarding environment/unlocked chemicals requested on 07/31/19.	F 689		

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F 689	Continued From page 5 The facility failed to provide an environment free from accident hazards over which the facility had control when the facility staff left poisonous chemicals in an unlocked cabinet to which residents had access.	F 689		
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 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	F 690		

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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 37 residents with 13 included in the sample. Based on observation, interview, and record review the facility failed to provide the appropriate cleaning for Resident (R) 32's urinary catheter bags to meet professional standards.

Findings included:

- Review of R32's physician's order sheet dated 07/25/19 revealed the following diagnoses: urinary tract infection (UTI), presence of catheter (insertion of a catheter into the bladder to drain the urine into a collection bag), benign prostatic hyperplasia (BPH)(non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections), obstructive and reflex uropathy (when urine cannot flow, either partially or completely through the ureter, bladder, or urethra due to some type of obstruction causing urine to flow backward into the kidneys).

Review of the quarterly "Minimum Data Set" (MDS) dated 04/04/19 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The resident required extensive assistance of two staff for toilet use, limited assistance of one staff for personal hygiene, and had an indwelling catheter.

Review of the annual MDS dated 07/01/19 revealed a BIMS score of 15, indicating intact

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cognition. The resident required extensive assistance of two staff for toilet use, required one staff assistance for personal hygiene, and had an indwelling catheter.

Review of the "Care Area Assessment" (CAA) dated 07/01/19 revealed the resident suffered from urinary retention, BPH, presented with impaired mobility, and required a urinary catheter.

Review of "Care Plan" dated 04/13/19, revised 07/05/19, revealed the resident had a catheter with potential for infection related to urinary retention and a diagnosis of BPH. The care plan provided information on the size of the catheter and instructed staff to change monthly and as needed (PRN). The care plan revealed the resident used a leg bag when out of bed, and staff were to replace with a urinary bag when R32 was in bed. The staff were to cleanse the tip of the bag when switching from the bed bag to the leg bag and clean the bag with soap and water before reconnecting. The staff were to encourage fluids and document input and output. The staff were to complete catheter care with soap and water every shift, observe the resident's skin for signs and symptoms of infection, check the catheter bag every 2 hours, and empty as needed.

Observation of R32 on 07/31/19 at 08:27 AM revealed Certified Medication Aide (CMA) O applied gloves and cleaned the catheter ends with alcohol swabs then changed R32's bed bag to a leg bag. CMA O drained the bed bag straw yellow urine. CMA O then cleansed the bed catheter bag with hot water, drained, and placed the bed catheter bag in a bag hung in R32's bathroom. Per interview at the same time with

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CMA O, staff reused the catheter bag and leg bag for a month before it was changed. CMA O stated the staff washed the leg bag the same way staff washed the catheter bag.

Observation of the central supply and the nurse's station on 08/01/19 at 06:28 PM revealed no vinegar located in either locked area. When asked about the lack of vinegar, Administrative Staff A and Administrative Nurse D said they did not know why there was not any vinegar and added the facility did fire the stock employee recently.

Interview with R32 on 08/01/19 at 04:47 PM revealed he had a history of UTI's. R32 said staff provided excellent catheter care. R32 reported he had never physically watched the CNA's clean his catheter bags and said the staff cleaned them in the bathroom.

Interview with CMA O on 07/31/19 at 08:31 AM revealed the staff used to wash the catheter bags with a water/vinegar mix but the staff now just used hot water and staff ensured to clean the attachment with the alcohol swabs before connecting the tubes. CMA O stated the vinegar mixture was one-part vinegar and three-parts water, and CMA O did not understand why the facility wanted the care staff to stop cleaning the catheter bags in that manner. CMA O stated the direct care staff did not have access to the vinegar.

Interview with CNA N on 08/01/19 at 05:51 PM revealed staff received training videos and in-services with hands-on training (on cleaning catheters). CNA N said she honestly thought all staff needed a refresher though, because one

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CNA would say one thing and the other CNA would say something else in regard to how staff were supposed to clean catheter bags. CNA N said supposedly staff were only supposed to use water to rinse the catheter bags. CNA N said if a resident displayed symptoms of a UTI she would notify the nurse.

Interview with CNA M on 08/01/19 at 05:46 PM revealed the staff training on catheter bag cleaning used to be with vinegar, but now staff completed catheter bag cleaning with soap and water to clean them out. CNA M said the administrative staff took all the vinegar away from direct care staff and she did not know if the facility even had vinegar currently.

Interview with Licensed Nurse (LN) G on 07/31/19 at 08:39 AM revealed R32 did have a current UTI, but she was not sure if that was a chronic condition for R32. LN G said when R32 got up in the morning, staff switched him from the bed bag to the leg bag, and the staff rinsed the (urinary catheter) bags with hot water and re-used those bags for a month until a new one was placed. LN G said the staff used to wash the catheter bags with water and vinegar, but said maybe the policy had changed.

Interview with Administrative Nurse D on 07/31/19 at 08:54 AM revealed R32's care plan should not instruct the staff to clean the catheter bags with soap and water, and said it should instruct the staff to clean the (urinary catheter) bags with the vinegar/water mixture. Administrative Nurse D stated the vinegar (used to clean the catheter bags) was in central supply and the CNA's needed to ask for it. Administrative Nurse D said she did not feel the way the staff cleaned the

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F 690	Continued From page 10 catheter bags had caused any infection and stated the UTI's had gone down in the last few months. Interview with Administrative Staff A on 07/31/19 at 08:50 AM revealed she expected the staff to clean the catheter bags with the vinegar/water mixture. Administrative Staff A said this was something staff were still working on with the CNAs and it did not surprise her the staff were unsure of the policy. Administrative Staff A said the policy for changing the (catheter) bags had not been updated since she took over her position and was one of the things the facility was still working on to roll out the new procedures for cleaning catheter bags. Review of catheter leg bag care policy dated 2/2016 revealed the catheter leg bag...would be cleaned daily. The solution to be used would be comprised of water and vinegar in the ratio of one-part vinegar to one-part water. The policy additionally instructed staff allow the liquid to stay in the bag for 30 minutes. The facility failed to provide the appropriate cleaning for R32's urinary catheter bags to meet professional standards.	F 690		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		

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§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 37 residents with 13 residents included in the sample. Based on observation, interview and record review the facility failed to ensure the completion of the monthly pharmacist "Medication Regimen Review" (MRR) to include the physician responses for Resident (R) 26, R5, and R21.

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Findings included:

- Review of R26's pharmacy "Medication Regimen Review" (MRR) revealed the following:
1. Missing MRR's noted for 07/2018, 08/2018, 09/2018, and 11/2018.
2. No physician responses recorded for the MRR on 12/2018 and 06/2019.

Review of R5's pharmacy MRR revealed the following:
1. Missing MRR's noted for 07/2018 and 11/2018.
2. No physician responses recorded for the MRR on 09/2018, 10/2018, and 12/2018.

Review of R21's pharmacy MRR revealed the following:
1. No physician responses recorded for the MRR on 05/2019 and 06/2019.

Interview with Administrative Staff A on 08/01/19 at 05:17 PM revealed the pharmacist completed the MRR monthly and submitted them to the physician. Administrative Staff A said the director of nursing (DON) followed up on the MRR's.

Interview with Administrative staff A on 08/05/19 at 02:52 PM revealed the prior DON had old pharmacy reviews in her office that were not completed.

Review of medication regimen review policy dated 11/2017 revealed upon completion of the MRR the facility designee and/or attending physician would respond to the recommendations in a timely manner. If no response was received from the attending physician within twenty-one business days of the initial requested review, the

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WESLEY TOWERS INC	700 MONTEREY PL HUTCHINSON, KS 67502

(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 756	Continued From page 13 DON would contact the facilities medical director or designee agent for requested responses/recommendations and the staff would doucment the attempted contact in the residents file. Any written and/or electronic communications provided to the facility would be filed and any attachments in electronic medical records under specific resident information. The facility failed to ensure the completion of the pharmacist Medication Regimen Reviews (MRR) to include the physician responses for Resident (R) 26, R5, and R21.	F 756		