STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

(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. The 2567 was electronically sent to the facility on 4/29/19.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to provide a significant change assessment for 1 of 12 sampled residents. (#26) Findings included: - Resident #26's quarterly (MDS) Minimum Data Set assessment, dated 12/9/18, documented the resident had a (BIMS) Brief Interview of Mental Status score of 3, which indicated severe cognitive impairment. The MDS recorded the resident required extensive assistance of 1 staff with dressing, toilet use, and personal hygiene, supervision with eating, and independent with bed	F 637		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/29/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

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F 637	Continued From page 1	F 637		

mobility, transfers and ambulation.

The quarterly MDS, dated 2/24/19, documented the resident was totally dependent on staff for transfer, dressing, eating, personal hygiene, toilet use, bathing, and required extensive of 2 staff with bed mobility and ambulation.

The 3/6/19 care plan directed 2 staff to ambulate with the resident, using a gait belt, every 2 hours and as the resident would allow. The care plan documented the resident was able to feed himself/herself at times but required heavy cueing and staff assistance at times.

The 1/15/19 at 3:00 PM and 3/31/19 at 10:35 AM nurse's notes documented the resident transferred with the assistance of 2 staff and a gait belt.

The 2/26/19 physician's progress note documented per the nursing staff, the resident required 2 staff assistance with (ADLs) Activities of Daily Living.

On 4/24/19 at 8:01 AM, observation revealed 2 staff held onto the back of the resident's gait belt and arms while ambulating with the resident.

On 4/25/19 at 10:08 AM, Direct Care Staff O verified 2 staff assisted the resident to transfer, toilet, and ambulate with a gait belt since January 2019.

On 4/25/19 at 9:33 AM, Administrative Nurse E verified the resident had a major change in his/her ADLs from the 12/9/18 MDS to the 2/24/19 MDS, and the 2/24/19 MDS should have been a significant change MDS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

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PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 637	Continued From page 2 On 4/25/19 at 10:47 AM, Administrative Nurse D verified the 2/24/19 MDS should have been a significant change MDS as the resident had a significant change in more than 2 areas from the 12/9/18 MDS to the 2/24/19 MDS. The facility's undated MDS and care plan policy documented care plan members would fill out the MDS sections that are pertinent to their department and give to the MDS/Care Plan coordinator. The coordinator would use this information to accurately fill out the MDS. The October 2015 Centers for Medicare and Medicaid Services, Department of Health and Human Services, Long-Term Care Facility (RAI) Resident Assessment Instrument 3.0 User's Manual, Version 1.13, defined a (SCSA) Significant Change in Status Assessment as a decline or improvement in a resident's status. The RAI Manual documented a significant change assessment should be completed no later than 14 days from the determination date of the significant change. The facility failed to complete a significant change assessment for Resident #26, who had an increased need for staff assistance after a decline in ADL function, placing the resident at risk for inappropriate care and assistance to meet the resident's needs.	F 637		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

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PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 684	Continued From page 3	F 684		

facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 12 residents of which 1 was reviewed for skin conditions, non-pressure related. Based on observation, record review, and interview the facility failed to ensure care planned interventions were implemented for a skin condition for 1 of 1 sampled resident. (#35)

Findings included:

- Resident #35's quarterly (MDS) Minimum Data Set assessment, dated 3/17/19, documented the resident had a (BIMS) Brief Interview for Mental Status score of 0, which indicated severe cognitive impairment, and was totally dependent on staff for all (ADLs) Activities of Daily Living. The MDS documented the resident was at risk for pressure ulcers, had a pressure reducing device for chair and bed, on a turning and repositioning program, and received hospice services.

The 9/24/18 (CAA) Care Area Assessment for pressure ulcers documented the resident had a therapeutic mattress on his/her bed as provided by the facility, on a turning schedule, and had a pressure relieving cushion in his/her wheelchair.

The 3/27/19 care plan documented the resident received hospice services, directed 2 staff to transfer the resident with a full lift, and the resident had an air mattress on his/her bed. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 4	F 684		

care plan directed staff to place heel protectors on the resident's heels and a flotation pillow under the resident's lower legs when in bed, to float his/her heels.

The 3/20/19 Braden scale assessment (a pressure ulcer risk prediction assessment) recorded a score of 14, which indicated the resident was at moderate risk for pressure ulcers.

The 3/29/19 skin assessment documented the resident had an intact blister to his/her right heel, which measured 7 (cm) centimeters x 4 cm.

On 4/23/19 at 9:11 AM, observation revealed the resident lying in his/her bed, Consultant Staff GG uncovered the resident, the flotation pillow in place under his/her lower calves, the heel protectors on both heels, and both heels rested on the bed. Observation revealed Consultant Staff GG removed the right heel protector and the right sock and revealed a golf ball sized flat purple area on the resident's right heel with no open area or drainage. Consultant Staff GG verified the area was a blister that was now heeled.

On 4/23/19 at 11:16 AM, observation revealed Nurse Aides M and N entered the resident's room, the resident lying in his/her bed, and both aides talked to the resident about getting up for lunch. The aides uncovered the resident, heel protectors in place on both heels, and a flotation pillow under his/her lower calves with both heels resting on the bed.

On 4/23/19 at 3:25 PM, observation revealed Nurse G and Administrative Nurse D enter the resident's room and talked to the resident. Both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 684	Continued From page 5	F 684		

staff uncovered the resident and the resident had heel protectors on both heels and a flotation pillow under his/her lower calves with both heels resting on the bed.

On 4/24/19 at 9:57 AM, observation revealed the resident sat in a recliner with heel protectors on both heels and both heels rested on the recliner foot rest with no flotation pillow under his/her lower legs.

On 4/25/19 at 7:37 AM, observation revealed Nurse Aides O and P entered the resident's room and observed the resident lying in his/her bed. Observation revealed both staff uncovered the resident, he/she had heel protectors on both heels and a flotation pillow under his/her lower calves, with both heels resting on the bed.

On 4/25/19 at 7:50 AM, Nurse Aide O verified the flotation pillow under the resident's lower legs did not keep the resident's heels floated off the bed.

On 4/25/19 at 11:10 AM, Administrative Nurse D verified the resident's care plan directed staff to place the flotation pillow under the resident's lower legs to float the resident's heels.

On 4/25/19 at 11:24 AM, Restorative Aide Q verified the flotation pillow was added to the resident's care plan to float the resident's heels off the bed.

The facility's undated Skin Integrity policy documented if an elder was determined to be at risk or had developed any skin integrity abnormalities, the nurse would implement action according to the specific skin issue identified per protocol, including but not limited to, preventing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 684	Continued From page 6 injury to the elder by maintaining and improving tissue tolerance to pressure in order to prevent injury and protect against adverse effects of external mechanical forces. The facility failed to correctly place the care planned flotation pillow for Resident #35's heels, placing the resident at risk for further skin breakdown.	F 684		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included 12 residents, with 5 reviewed for	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 757	Continued From page 7	F 757		

unnecessary medication use. Based on observation, record review, and interview the facility failed to ensure 1 of 5 sampled residents, when staff failed to follow the facility's bowel protocol, after a resident had lack of bowel movements. (#5)

Findings included:

- Resident #5's physician order sheet, dated 2/14/19, documented the resident had a diagnosis of constipation (difficulty passing stools). The order sheet instructed staff to apply a Fentanyl (narcotic pain medication used to treat severe pain), 25 (mcg) micrograms, per hour, topical patch, on the resident, and to change the patch every 72 hours.

The quarterly (MDS) Minimum Data Set assessment, dated 1/6/19 documented the resident had a (BIMS) Brief interview for Mental Status score of 0, which indicated severe cognitive impairment. The MDS documented the resident was independent with bed mobility, transfers, walk in room and corridor, and required limited staff assistance with locomotion on and off unit, dressing, eating, toilet use and personal hygiene. The MDS documented the resident received an opioid (narcotic pain medication) every day during the 7 day look back period. The MDS documented the resident was always continent of bowel and had no constipation during the 7 day look back period.

The 1/16/19 care plan documented the resident was continent of bowel and bladder at times and instructed staff to administer (PRN) as needed laxative medications, per facility bowel protocol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 757	Continued From page 8	F 757		

The bowel movement record lacked documentation of a bowel movement on the following dates:
January- 16-22 (7 days) no documentation staff administered treatment for lack of bowel movement.

February- 16-22 (7 days) staff administered a Bisacodyl suppository (laxative medication administered rectally to stimulate a bowel movement), on 2/13 and 2/28 without follow up results, or documentation staff administered (MOM) Milk of Magnesia (medication used to treat constipation), as the 1st line of treatment per the facility's standing orders.

March-21-27 (7 days) staff administered a Bisacodyl suppository, on 3/4, 3/10, 3/15, 3/20 and 3/27 without documentation of follow up results or use of MOM, 1st line of treatment.

April-10-14 (5 days) and 18-23 (7 days) staff administered Bisacodyl suppository on 4/15 without documentation of follow up results or use of MOM, 1st line of treatment.

The 4/15/19 at 9:10 AM, nurse's note documented the resident lacked a bowel movement for 9 days, staff administered a Bisacodyl suppository rectally to the resident, and the nurse received an order from the hospice nurse to administer a fleets enema (introduction of a solution into the rectum for cleansing or therapeutic purposes) one time, and if the resident had no results from the enema, contact hospice for further orders.

On 4/24/19 at 7:39 AM, observation revealed the resident sat in the kitchen commons area, dozing,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

(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 757	Continued From page 9	F 757		

staff awakened the resident to assist him/her with eating, the resident reported he/she had to use the bathroom, and staff assisted the resident to the bathroom.

On 4/25/19 at 1:55 PM, Nurse G stated the facility bowel protocol for lack of bowel movement was, after the resident had gone 3 days without a bowel movement staff should administer MOM, if no results on the 6th day staff should insert a Bisacodyl suppository rectally, then if no results on the 9th day staff are to administer an enema to the resident. Nurse G stated the night nurse looked through the charting and made a list of residents who had no bowel movement in the past 3 days, gave the list to the day nurses, and the day nurse would start the bowel protocol.

On 4/25/19 at 11:43 AM, Administrative Nurse D verified the above findings, regarding the resident's lack of bowel movements on the above dates, and verified staff failed to follow the facility's bowel protocol.

The facility's 10/21/18 Standing Orders documented residents are given 3 full days to have a bowel movement, on the morning of the 4th day staff should administer MOM, 30 (ml) milliliters, if no results from MOM, on day 5 insert a Bisacodyl, 10 (mg) milligram suppository, if no results from the Bisacodyl suppository, on the morning of day 6 administer a fleets enema, and if no results from the fleets, staff should notify the physician for further instructions.

The facility failed to provide interventions for lack of bowel elimination for, Resident #5, after he/she went several days without a bowel movement on several different occasions, placing the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 757	Continued From page 10 at risk for pain and bowel obstruction (a blockage preventing the contents of the intestines from passing normally through the digestive tract).	F 757		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included 12 residents, with 8 reviewed for medication administration. Based on observation, interview, and record review the facility failed to correctly administer medications to 2 of 8 residents reviewed resulting in an error rate greater than 5%. (#14, #17) Findings included: - Resident #14's signed fax from the physician, dated 4/15/19, directed staff to discontinue the resident's Namenda (medication prescribed for failing memory and confusion) 5 (mg) milligram, twice a day. Resident #17's physician order, dated 2/6/16, directed staff to administer Metoprolol (medication given for high blood pressure) 25 mg, ½ tablet, by mouth, twice a day, and hold if pulse was less than 50. Resident #17's physician order, dated 1/2/18, directed staff to apply Voltaren gel (gel applied to the skin to treat pain of the joints) 1 (gm) gram	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

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F 759	Continued From page 11	F 759		

topically (the surface of part of the body) to the resident's right shoulder, twice a day, for pain.

On 4/23/19 at 4:38 PM, during medication administration, observation revealed (CMA) Certified Medication Aide R documented administration of the Voltaren gel to Resident #17, but failed to apply the gel to the resident, and placed it back in the medication cart. Further observation revealed Nursing Staff R failed to obtain the resident's pulse prior to administration of Metoprolol, as directed.

On 4/24/19 at 7:07 AM, during medication administration, observation revealed CMA S administered Namenda 5 mg to Resident #14, after the medication had been discontinued on 4/15/19.

On 4/23/19 at 4:54 PM, CMA R stated he/she forgot to apply the Voltaren gel and verified he/she failed to check the resident's pulse prior to administering Metoprolol, as ordered.

On 4/24/19 at 7:38 AM, Administrative Nurse E verified the order for Namenda, 5 mg, by mouth, twice a day, had been discontinued on 4/15/19, and Licensed Nurse G had not discontinued the medication as ordered.

On 4/25/19 at 2:32 PM, Administrative Nurse D verified Resident #14's Namenda had been discontinued on 4/15/19 and had not been removed from his/her (MAR) Medication Administration Record. Administrative Nurse D verified Resident #17's pulse should have been obtained prior to administration of the Metoprolol, and the Voltaren gel should have been applied as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILLIPS COUNTY RETIREMENT CENTER	EAST HWY 36, PO BOX 628 PHILLIPSBURG, KS 67661

(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 759	Continued From page 12 The facility's undated Administration of Medication by Unit Dose Method policy documented all medications would be administered in a professional manner, using good hand washing technique before medication pass and as indicated during the medication pass. After the proper time, resident, and medication have been located in the chart, the "blister" card (a card with individually wrapped medications) would be taken out of the cart. Each medication would then be checked with the MAR, and signed off before it was dispensed into a medication cup. The facility failed to correctly administer medications to Residents #14 and #17, resulting in a medication error rate greater than 5%, placing the residents at risk for adverse side effects.	F 759		
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.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E658	A. BUILDING _____ B. WING _____	04/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 13	F 812		

§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 39 residents. Based on observation, interview, and record review the facility failed to store and prepare food, and ensure the kitchen area kept in accordance with professional standards for food service safety for 38 of 39 residents, who received food prepared in the kitchen, and ice from the ice machine.

Findings included:

- On 4/22/19 at 2:58 PM, during the initial tour of the kitchen pantry, observation revealed the following outdated food items on pantry shelves. Quaker Quick Barley, 6 boxes, outdated 1/19/18; Libby's pumpkin, 2 cans, outdated 10/31/18; Old El Paso enchilada sauce, 1 can, outdated 12/9/18.

On 4/22/19 at 3:08 PM, observation revealed multiple food items in the pantry which lacked dates when the items were received, and several food items which lacked dates when they were opened. Dietary Staff BB verified the food items lacked a received and/or open date.

On 4/22/19 at 3:32 PM, observation revealed the March and April temperature logs for the 100 and 200 hall dining area refrigerator and freezer lacked documentation of temperature readings for March 2, 3, 9, 10, 16, 17, 23, 24, 30, 31, and April 6, 7, 9, 10, 13, 14, 20, and 21.

On 4/22/19 at 4:17 PM, observation revealed the

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	17E658	A. BUILDING _____ B. WING _____	04/25/2019

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F 812	Continued From page 14	F 812		

March and April temperature logs for the 400 hall dining area lacked refrigerator and freezer temperature readings on March 16, 17, 23, 24, 30, 31, and April 6, 7, 9, 10, 13,14, 20, and 21.

On 4/23/19 at 9:35 AM, observation revealed the April temperature log for the refrigerator and freezer just outside the kitchen lacked documentation of temperatures on April 6, 7, 9, 10, 13, 14, 20, and 21.

On 4/24/19 at 12:37 PM, observation revealed the end of the ice machine drain tubing was less than an inch from the floor drain. Dietary Staff BB verified the existing air gap was less than the required 2 inches.

On 4/25/19 at 1:11 PM, observation revealed the kitchen floor had multiple small nicks, cuts, damaged and missing areas of vinyl flooring. Approximately 2" wide flooring was missing 2/3 of the way around the floor drain, there were multiple slits in the flooring from pipes to the wall, and the slits and floor seams were slightly raised and dark colored. Observation revealed a large round (10-12") burn mark on the floor by the stove, several smaller burned areas, and turned up edges along the bottom of the cupboards coming loose. The air vent under the cupboards had multiple rusty areas, the vent under the handwashing sink completely rusted, and the vent on the wall about 7 feet up and to the right of the handwashing sink had small spots of rust, and rusty water streak stains visible 12-18 inches below the vent. Dietary Staff BB verified these observations and stated he/she was unsure of the floor's age.

On 4/22/19 at 5:30 PM, Dietary Staff CC stated

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F 812	Continued From page 15	F 812		

Maintenance Staff U checked the temperatures in the refrigerators and freezers and documented the results on the log, but he/she was unaware who recorded the temperatures on the weekends.

On 4/23/19 at 8:05 AM, Maintenance Staff U stated no one checked the refrigerator or freezer temperatures on the days he/she was not at the facility.

On 4/25/19 at 1:16 PM, Dietary Staff BB verified the undated and outdated food in the pantry, the refrigerator/freezer temperature logs lacked complete temperature records, and there was no one assigned to record refrigerator and freezer temperatures when Maintenance Staff U was not at the facility.
On 4/25/19 at 1:38 PM, Administrative Staff A stated he/she thought the kitchen flooring was installed in the 1990's (20-30 years ago), and would be evaluated for repair or replacement.

The facility's undated Food Storage policy documented when new food items are purchased from the store or delivered by the food supplier, food will be dated by staff when stocked on shelf or put in freezer/refrigerator. When a food item is opened, an open date will be placed on the container. The dietary manager or designee will check for expiration dates on food containers on a weekly basis.

The facility's undated Preventive Maintenance and Inspections policy documented that interior inspection of the facility would be conducted and documented weekly, including the condition of flooring, torn or missing flooring, cove base integrity, and cleanliness of flooring. The policy further documented the kitchen would be

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F 812	Continued From page 16 inspected and documented weekly, including refrigerators and freezers. Upon request, the facility did not provide a policy regarding the air gap for the ice machine, or who would be responsible for checking refrigerator and freezer temperatures when Maintenance Staff U was not at the facility. The facility failed to store and prepare food and ice in accordance with professional standards for food service safety for 38 of 39 residents in the facility who received food prepared in the kitchen, placing the residents at risk of receiving unsafe food and drinks.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the 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	F 880		

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F 880	Continued From page 17	F 880		

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 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

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F 880	Continued From page 18 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 had a census of 39 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections, when staff failed to sanitize or properly wash hands during administration of medications to 3 residents. (#5, #9, #17) Findings included: - On 4/23/19 at 4:38 PM, during medication administration, observation revealed Medication Aide R entered Resident #39's room and administered the resident his/her medications. Medication Aide R washed his/her hands, turned off the water with his/her washed hand, dried hands with a paper towel, then returned to the medication cart outside the resident's room. Observation revealed Medication Aide R sat up Resident #17's medications in a medication cup, then without sanitizing his/her hands, entered Resident #17's room, administered the resident's medications, washed his/her hands, turned off the water with his/her washed hand, then dried hands with a paper towel. Further observation revealed Medication Aide R returned to the medication cart, outside the resident's room. Medication Aide R sat up Resident #5's medications, entered the resident's room, administered Resident #5's	F 880		

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F 880	Continued From page 19	F 880		

medications, washed his/her hands, turned the water off with his/her washed hand, dried hands with a paper towel, then left the resident's room and returned to the medication cart.

On 4/23/19 at 4:54 PM, Medication Aide R verified the above observations and stated he/she forgot to apply the sanitizing gel to his/her hands between administration of resident's medications.

On 4/25/19 at 2:32 PM, Administrative Nurse D stated staff should dry their hands after washing them, then use a paper towel when turning off the faucet.

The facility's undated Hand Hygiene policy documented the hand washing procedure as follows:
1. Wet hands with running water
2. Apply hand washing agent to hands.
3. Vigorously rub hands together for at least 20 seconds, covering all surfaces of hands and fingers including between fingers and under fingernails.
4. Rinse hands thoroughly with water and with hands angled down in the sink. Dry hands thoroughly with a disposable towel.
5. Use disposable towel to turn off the water.
6. Use disposable towel to open door if exiting room then discard disposable towel.

The facility failed to provide a safe, sanitary and comfortable environment when staff failed to sanitize or properly wash hands during medication administration to Resident #5, #9, and #17, placing the residents at risk for receiving communicable diseases and infections.