| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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<br><br>The following citations represent the findings of a Health Resurvey and Complaint Investigaton #'s 134476, 136373, 138074, and 139234.<br><br>The 2567 was electronically sent to the facility on 04/09/19. | F 000 | | |
| F 625 SS=E | Notice of Bed Hold Policy Before/Upon Trnsfr<br>CFR(s): 483.15(d)(1)(2)<br><br>§483.15(d) Notice of bed-hold policy and return-<br><br>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-<br>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;<br>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;<br>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and<br>(iv) The information specified in paragraph (e)(1) of this section.<br><br>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. | F 625 | | |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 625 | Continued From page 1 | F 625 | | |

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 91 residents. The 20 residents selected for review included 5 residents reviewed for presence of written bed hold notice upon transfer to the hospital. Based on record review and interview the facility failed to provide a written bed hold notice for these 5 residents reviewed, including 3 residents (# 53, #295, #5), for two hospitalizations, and 2 residents (#39, #18) for one hospitalization.

Findings include:

- Review of the following 5 residents medical records revealed lack of the bed hold policy provided to the resident and/or responsible party as follows:

1). Resident #53's, nurses notes, dated 9/17/19, revealed the resident admitted to the hospital overnight for observation.

Review of the medical record revealed lack of a written bed hold for the transfer to the hospital.

Nurses notes, dated 10/26/18, revealed the resident was sent to ER, then admitted to the hospital.

Review of the medical record revealed lack of written bed hold for transfer to the hospital on 10/26/18.

2). Resident #295's 8/1/18 and 12/1/18 discharge assessment MDS (minimum data set), revealed the resident transferred to the hospital on these dates.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 625 | Continued From page 2 | F 625 | | |

Review of the medical record lacked written bed hold for both transfers.

3). Resident #5's 7/13/18 discharge assessment MDS and the 2/25/19 nurses notes, revealed the resident transferred to the hospital on both of these dates.

Review of the medical record lacked written bed hold for both transfers.

4). Resident #39's nurses notes, dated 12/25/18, revealed the resident admitted to the hospital.

Review of the medical record lacked written bed hold for the transfer.

5). Resident #18's 2/18/19 discharge assessment MDS, revealed resident #18 transferred to the hospital.

Review of the medical record lacked written bed hold for the transfer.

Interview, on 4/3/19 at 03:34 pm, with social services staff D, responsible for bed holds, confirmed that bed holds are done only on an annual basis and not when a resident transfers to the hospital.

The facility policy for Bed-Hold procedure, revised 10/19/18, instructs that upon admission and when a resident is transferred for hospitalization or for therapeutic leave, a representative of the facility will provide information concerning the bed-hold

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 625 | Continued From page 3<br>policy.<br><br>The facility failed to provide these five residents and/or his/her responsible person with a written bed hold notice, at the time of the residents transfer to the hospital. | F 625 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to 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.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 91 residents. The 20 residents selected for review included 2 residents reviewed for skin conditions. Based on observation, interview, and record review, the facility failed to provide prompt, appropriate treatment for these 2 residents (#12 and 58) reviewed for skin wounds.<br><br>Findings included:<br><br>- Record review, of physician progress notes, dated 2/18/19, for resident #58, included diagnosis hypertension (elevated blood pressure) , coronary artery disease (abnormal condition that may affect the flow of oxygen to the heart), Atrial fibrillation (rapid, irregular heart beat) , and congestive heart failure (a condition with low heart output and the body becomes congested | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 684 | Continued From page 4 | F 684 | | |

with fluid).

The quarterly MDS (minimum data set), dated 2/15/19, assessed the resident of having a BIMS (brief interview of mental status) score of 13, had a skin tear present, was receiving application of dressings and ointments, and received an anticoagulant (a medication that thins the blood) for 7 days of the MDS assessment period.

The skin CAA (care area assessment), dated 8/27/18, revealed the resident required assistance with mobility and was at risk for skin breakdown related to immobility, incontinence, and chronic disease process.

The care plan, dated 2/18/19, instructed the staff to follow the facility policies/protocols for the prevention/treatment of skin breakdown, and that nursing was to assess skin weekly and during cares. The care plan further instructed that the blood thinner he/she takes can cause increased bruising and to monitor skin routinely.

Record review, of the skin observation tool, dated 3/18/19, revealed no skin conditions noted.

Observation, on 03/28/19 01:40 PM, revealed the resident to have 3 steri-strips in place to the left forearm. The resident interview, at that time, confirmed there was a wrap that was removed yesterday, there was a pus like fluid on the sore, the area was cleaned, and the steri-strips were left in place. Furthermore, the area happened a couple of weeks ago when his/her shirt sleeve caught his/her watch and caused a tear.

Record review, of nurses note, dated 3/31/2019 at 03:22, revealed the resident complained of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 684 | Continued From page 5 | F 684 | | |

his/her left leg bleeding, a skin tear was present that measured 5cm x 3cm, was cleansed with saline wound flush, and a DuoDerm (a wafer type moisture-retentive wound dressing used for partial and full-thickness wounds leaking fluids) thin spot was applied.

The Treatment record, dated 3/2019, revealed a code of 9 for the skin assessment due on 3/25/19 and lacked a treatment order for left forearm and left leg.

The skin observation tool, dated 4/1/19, revealed the resident skin to be dry, warm, and intact; and no new skin conditions observed.

Observation, on 4/2/19 at 2:00 pm, revealed steri-strips in place to left forearm.

Observation, on 4/3/19 at 07:56 am, revealed the dressing in place to the left shin that lacked a date, time, and initials. Steri-strips remained in place to left forearm.

Interview, on 4/3/19 at 07:58 am, with administrative nursing staff B, confirmed the dressing on the left shin lacked a date, time, or initials and should have a treatment order in place. Staff B also confirmed the left forearm should be monitored and placed on the treatment record, and skin areas should be on the treatment record and assessed with weekly skin assessments.

Interview, on 4/3/19, at 8:10 am, with administrative nursing staff B, confirmed a treatment order for the left leg and the left forearm were not in place.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 684 | Continued From page 6 | F 684 | | |

Observation and interview, on 4/3/19 at 8:15am, revealed administrative nursing staff B assessed the left forearm, steri-strips had been removed, and he/she confirmed the area to the left forearm was healed. Furthermore, he/she confirmed a thin duoderm was present to the resident's left leg. Staff B removed the dressing and cleansed with wound wash, the wound lacked drainage but was open. Staff B dried the area with gauze and measured the wound to be 0.5cm in length and 0.3cm in width.

Observation and interview, on 4/3/19 at 8:22am, of administrative nursing staff B, confirmed the treatment order per the wound protocol standing orders was to clean the area, apply triple antibiotic ointment and cover. Then, staff B, gathered supplies and provided treatment to the left leg.

Interview, on 4/3/19 at 9:59 am, confirmed that the code 9 on the treatment record for the skin assessment on 3/25/19, means other, see progress note.

Review of the progress notes, dated 3/25/19-3/31/19, did not reveal any information regarding skin assessment on 3/25/19.

The facility dressing change policy, dated 1/14/11, indicated to document dressing change as required, noting condition of wound; and to write the date, time, and initials on the dressing.

The facility standing protocols, dated 3/13/19, reveals instructions for minor cuts and scrapes, to cleanse the area, may apply triple antibiotic ointment once and apply dressing; do not repeat the triple antibiotic on subsequent days.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 684 | Continued From page 7 | F 684 | | |

The facility failed to provide appropriate treatment of the resident's wound to ensure healing and prevent infection.

-Review of resident #12's physician order sheet, dated 1/4/19, revealed diagnosis of PVD (Peripheral vascular disease-abnormal condition affecting the blood vessels), HTN (Hypertension-elevated blood pressure), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), pain, MDD (major mood disorder), type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and polyneuropathy (a general degeneration of peripheral nerves that spreads toward the center of the body).

The annual MDS (minimum data set), dated 9/28/19, assessed the resident with a BIMS (brief interview for mental status) score of 15 indicating little or no impairment (13-15), that resident was at risk for pressure ulcers. The resident had pressure relieving device in chair and ointment or medication applied. The resident received dialysis.

The quarterly MDS, dated 12/28/19, assessed the resident with a BIMS score of 8 indicating moderate cognitive impairment (8-12), that the resident was at risk for pressure ulcers, had open lesion(s) other than pressure ulcers, rashes, or cuts, moisture associated skin issue. The resident receives the application of non surgical dressing, ointment, or medication, and has a pressure relieving device in chair. The resident recieved dialysis.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 684 | Continued From page 8 | F 684 | | |

The CAA's (care area assessment) for ADL's (activities of daily living), dated 9/28/19, indicated the resident required staff assistance with ADL's due to weakness/chronic disease processes, LE (lower extremity) amputation. The resident is often tired and may refuse bathing particularly due to chronic disease process and dialysis.

The care plan, dated 12/28/18, directed staff that resident needed assistance with ADL's. That the resident has impaired physical activity, and does not like more than 2 people in the room when providing his/ her cares.

Observation, on 04/01/19 at 1:06 pm, of a dressing change revealed licensed nursing staff C, donned gloves, removed the dressing to the left upper arm revealing a dialysis shunt, discarded gloves, performed hand hygiene, donned clean gloves, feels thrill (a fine vibration felt which reflects the blood flow by a dialysis resident's shunt), listens to bruit (blowing or swishing sound heard which reflects the blood flow with a dialysis resident's shunt), removed gloves, no hand hygiene, new gloves donned and dressing on the residents back was removed, cleansed and a new dressing applied with same gloves on. Staff C then asks the resident the questions on the facility dialysis check list sheet. Staff C acknowledged that hand hygiene should occur before and after donning/removing gloves, and gloves should be changed from site to site, and from removing a dressing to cleansing a wound, and again when applying a clean dressing.

The updated facility policy on dressing changes, dated 1/14/11, states open dressing pack, put on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 684 | Continued From page 9<br>first pair of disposable gloves, remove soiled dressing and discard, dispose of gloves, wash hands, put on second pair of disposable gloves, apply cleansing solution, apply dressing, remove gloves.<br><br>The updated hand hygiene policy, dated 2/12/19, advises staff indications for hand-washing before and after contact with fluids or excretions, mucous membranes, non intact skin, and wound dressings, even if hands are not visibly soiled after removing gloves.<br><br>The facility failed to ensure proper hand sanitization and glove change during this resident's dressing change to prevent cross contamination and the spread of infection. | F 684 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 91 residents with 20 residents selected for review which | F 686 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 10 | F 686 | | |

included 3 residents reviewed for pressure ulcers. Based on observation, interview and record review the facility failed to ensure proper hand washing and glove use during dressing changes for 2 ( #48 and #74) of the 3 residents reviewed, and failed to ensure uncompromised pressure relieving measures for 1 (#78) of the 3 residents reviewed.

Findings included:

- Review of resident #78's physician order sheet, dated 1-15-19, revealed diagnoses included Multiple Sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), muscle spasm, major depressive disorder, neuropathy (disease of the nerves), vascular disease (disease of the arteries and veins), anemia (condition without enough healthy red blood cells to carry adequate oxygen to body tissues), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and osteomylitis (local or generalized infection of the bone and bone marrow).

Review of the significant change MDS (minimum data set), dated 12-7-18, assessed the resident with a BIMS (brief interview for mental status) score of 13, indicating normal cognitive function, inattention that fluctuated, no behaviors, total dependence for bed mobility, transfers, toileting and personal hygiene, independent with eating. This MDS assessed the resident with no range of motion impairment in the upper extremities, and impairment in the lower extremities, at risk for pressure ulcers, 1 stage 1, 4 stage 3, with 2 present upon admission, 1 stage 4 and 2 arterial/venous ulcers, with interventions of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 11 | F 686 | | |

pressure relieving device in bed, chair, turn and reposition program, dressing changes.

The CAA (care area assessment), for pressure ulcers, dated 12-7-18, advised staff good nutrition and hydration to promote healthier skin, to identify and document potential causative factors and eliminate/resolve where possible, Prevlon boots for pressure relief to heals bilaterally, to turn upon rounds, and the resident will position him/herself on his/her back and staff advised to reposition as often as needed to help relieve pressure off of pressure areas. The resident to have a pressure relieving air mattress.

The care plan, updated 3-12-19, advised staff when repositioning and transferring the resident to protect against the effects of external mechanical forces such as pressure, friction and shear. The care plan advised staff to provide Prevlon boots for pressure relief, pressure relieving air mattress, pressure relieving cushion to chair.

A hospice wound care note, dated 1-14-19, advised staff to provide a low air loss mattress, with setting at 150 pounds, alternating pressure, ensure fewest layers in between the resident and mattress, to reposition every 2 hours as tolerated with advisement that the resident was a hospice resident, and these chronic pressure ulcer wounds were present for over a year due to immobility, with goals to prevent infection and prevent new areas of breakdown.

The Braden score ( a scale to determine a resident's risk of developing pressure related injuries) evaluated the resident with a score of 12 on 5-31-18 (10-12 high risk), 9 on 8-27-18 (<9

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 12 | F 686 | | |

severe risk), 12 on 11-24-18, 11 on 2-24-19.

Review of the wound assessments, dated 12-25-18 revealed a right heel SDTI (suspected deep tissue injury) with measurements of 2.7 by 4.3 by 1 cm (centimeter) depth, 75% (percent) necrotic (dead) and 25 % epithelial tissue, with Prevlon boots, alternating pressure mattress and side rails for positioning. (pressure relieving mattress and Prevlon boots on care plan dated 11-8-17). The wound assessment dated, 3-31-19, revealed the right heel pressure ulcer, identified as ulcer #7, with the date of development (blank), stage 3 with measurements of 4 by 5 cm, depth 1.5 cm, with 4.2 centimeter tunneling from 11:00 o'clock to 3:00 o'clock.

Review of the wound assessments, dated 12-3-18 , revealed the ball of the left foot pressure ulcer, identified as ulcer #9, SDTI, (identified on 11-16-18), with measurements of 3.9 by 8.8 cm. no depth (with boots as intervention in place). The wound assessment, dated 3-31-19, revealed left foot ulcer measurements of 2.3 by 4 cm with a depth of 0.39 cm, 25 % necrotic/slough.

Observation, on 4-3-19 at 9:30 am, revealed the resident positioned in bed with his/her head of the bed elevated at approximately a 45 degree angle.

Interview, on 4-3-19 at 9:30 am, with the resident revealed the wounds have been present for years. The resident stated staff repositioned the him/her frequently and used pillows for positioning and comfort. The resident stated he/she could use his/her hands and arms but did not have the use of his/her legs due to illness (multiple sclerosis). The resident further stated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 13 | F 686 | | |

that he/she did not always allow staff to reposition him/her.

Observation, on 4-3-19 at 10:29 am, revealed the resident sitting in bed, with the head of the bed elevated at approximately a 45 degree angle. Licensed nursing staff M removed the blankets covering the resident's feet to reveal the resident's left foot (enclosed in a pressure relieving boot directly in contact with the foot board of the bed. The resident's pressure relieving boot contained an egg crate-like foam padding. Licensed nursing staff M stated, at that time, these were not the resident's usual pressure relieving boots as they had been sent to laundry for cleaning. Staff M proceeded to provide wound care to the resident's left foot, and measured the left foot pressure ulcer as 2.5 cm in length by 1.1 by 1.2 which contained gray/yellow slough and the area below the resident's toes as 4 by 3 cm which contained tissue red in color, beefy constancy with 2 white areas of a structure (tendon like-structures). Staff M cleansed the areas with wound cleanser, applied skin prep to the peri wound, applied hydrogel an ABD (large thick gauze dressing) and wrapped the entire foot with kerlix (a stretchy type of gauze). Staff M questioned the resident if he/she felt any pain or discomfort during the dressing change and manipulation of the resident's feet, and the resident stated he/she did not feel anything in his/her feet. Staff M removed the dressing with an area of approximately 5 centimeters saturated with serous drainage from the resident's right foot and measured the area on the resident's right heel as 6 by 3.8 cm with a depth of 1.2 cm and tunneling 4.5 cm in an area from 11:00 o'clock to 3:00 o'clock. Staff M cleansed the wound with wound cleanser, applied

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 14 | F 686 | | |

Mesalt packing to the tunneling, and placed silver alginate on the beefy red wound bed. Staff M reapplied the pressure relieving boots to both feet. Staff M stated at that time he/she would continue with dressing changes to the resident's back, periarea and coccyx and hips, but the resident decline surveyor observation of these wounds.

Observation, on 4-3-19 at 12:19 pm, revealed the resident positioned in bed with the head of the bed elevated approximately 45 degrees, as the resident ate fruit cocktail. The resident's bilateral feet were contained in the egg crate lined boots. The resident's left foot was positioned directly on the the footboard.

Interview, on 4-3-19 at 12:19 pm with direct care staff G, revealed he/she repositioned the resident approximately at 11:30 am, but the resident routinely repositioned the pillows him/herself, placing the resident on his/her back.

Interview, on 4-3-19 at 1:15 pm, with licensed nursing staff M, confirmed the resident often removed and repositioned pillows which resulted in change in position. Staff M confirmed the resident did slide down in the bed, but thought the pressure relieving boots would help distribute the pressure of the footboard. Staff M stated the resident's usual pressure relieving boots were in the wash, but did find them in the clean laundry, at that time.

Interview, on 4-3-19 at 1:15 pm, with direct are staff U stated he/she would apply the newly found (resident's usual) pressure relieving boots, at that time.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 15 | F 686 | | |

Observation, on 4-3-19 at 1:25 pm, revealed the resident positioned sitting upright in bed at approximately a 45 degree angle. The resident's feet were encased in the newly found pressure relieving boots, and staff M was able to get his/her hand between the boot and the foot board, however the foot was up against the metal bar holding the footboard on the bed frame.

Interview, on 4-3-19 at 1:30 pm, with administrative nursing staff A, revealed the facility usually ordered pressure relieving boots but did not have specific brand name (Prevlon) pressure relieving boots available. Staff A stated he/she would advise staff to observe the resident's foot position hourly to prevent pressure against the foot board.

The facility policy for pressure ulcers, revised 5-25-16, advised staff a resident having a pressure ulcer receives the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing.

The facility failed to provide presssure ulcer care in a manner to promote healing of the resident's left heel pressure ulcer when staff failed to ensure the resident's feet did not push up against the bed foot board which in turn reduced the effectiveness of the pressure relieving boots.

- Review of resident # 74's physician order sheet, dated 12-7-18, revealed diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion), muscle spasms, neruogenic bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system), thrombosis of deep veins, and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 16 | F 686 | | |

diabetes(when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

The annual MDS (minimum data set), dated 11-16-18, assessed the resident with a BIMS (brief interview for mental status) score of 6 indicating severe cognitive deficit, verbal behaviors 1-3 days, required extensive assistance with bed mobility. The resident had no impairment in range of motion in upper or lower extremities, at risk for pressure ulcers with 2 unstageable pressure ulcers, pressure reducing device in bed, and on a turn and repositioning program.

The CAA (care area assessment), dated 11-16-18, for pressure ulcers, assessed the resident with 2 SDTI (suspected deep tissue injury to bilateral heels).

The care plan, updated 3-12-19, advised staff the resident had SDTI to bilateral heels, advised to turn and position the resident, avoid positioning the resident on his/her back to limit pressure to the coccyx, pressure relieving boots to feet bilaterally, and low air loss mattress. Resident requires extensive assist with ADL's (activities of daily living).

The physician's order, dated 10-8-18, advised staff to cleanse the left heel ulcer with wound cleanser, apply betadine, cover with ABD (a thick gauze dressing), and wrap with kerlex (elastic type gauze) daily.

Observation, on 4-1-19 a 7:50 am, revealed the resident positioned in bed with bilateral off loading boots. Licensed nursing staff O prepared to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 17 | F 686 | | |

provide wound care to the resident. Staff O washed his/her hands, donned gloves, removed the resident's dressing, staff O then, wearing the same gloves, cleansed the area with wound cleanser, removed gloves and performed hand hygiene. Staff O then applied new gloves and applied Vanicream to the resident's foot/toes then took the gloves off, did not perform hand hygiene, put on another pair of gloves, and applied betadine (swabs) to the left heel ulcer, changed gloves, staff O did not wash his/her hands, donned another pair of gloves and placed the ABD (thick gauze dressing) on the wound, and wrapped the foot with kerlex (a type of strechy gauze). Direct care staff O measured the left foot eschar at 3.4 by 3.3 cm (centimeter) and an area on the left heel inner side measured 1.5 by 1 cm with gray eschar (dead skin and tissue).

Interview, on 4-1-19 at 8:30 am, with licensed nursing staff O revealed the resident admitted (11-7-17) to the facility with pressure ulcers on his/her left lateral ankle and great toes, and had pressure relieving boots and air mattress in place at that time.

Interview, on 4-2-19 at 2:24 pm, with administrative nursing staff, Q revealed the resident had a barriatric bed with a pressure relieving mattress, and pressure relieving boots when first admitted. Staff Q stated at the time of the development of the pressure ulcer on the left heel, the resident was on prednisone for severe pain, as a result the prednisone, the resident had compromised healing. Staff Q stated the integrity of the pressure relieving boot was examined and the new pressure relieving boots were applied as was a change in bed and low air loss mattress.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 18 | F 686 | | |

Interview, on 4-1-19 at 2:55 pm, with consulting medical staff R, revealed the resident at high risk for pressure ulcer development due to diabetes, peripheral vascular disease (abnormal condition affecting the blood vessels) and immoblitiy.

The facility policy for hand hygiene, dated 3-12-19, advised staff to wash hands before and after contact with body fluids, excretions, mucous membranes, non-intact skin, and wound dressings even if hands are not visible soiled. Staff advised to wash hands after removing gloves.

The facility policy for dressing changes, revised 1-14-11, advised staff to put on first pair of disposable gloves, removed soiled dressing and dsicard, wash hands and put on second pair of disposable gloves.

The facility failed to ensure staff provided a dressing change with proper hand hygiene and glove changes to promote healing and prevent cross contamination and development of infection to the resident's pressure ulcer.

- Review, of resident #48's, signed physician order sheet, dated 11/28/18, revealed diagnosis including dementia (progressive mental disorder characterized by failing memory, confusion), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) type 2, edema, and pain.

The quarterly MDS (minimum data set), dated 11/9/18, assessed the resident with BIMS score

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 19 | F 686 | | |

of 11, indicating moderate cognitive deficit (8-12), requiring extensive assist of 2 with personal hygiene, total dependence of 2 with toilet use, dressing, bed mobility and transfers. The resident had one stage 2 pressure ulcer with pressure reducing devices in bed and wheelchair. Resident on a repositioning/ turning program. Had pressure ulcer care, application of dressing, and ointment or medication.

The annual MDS (minimum data set), dated 2/8/19, revealed BIMS (brief interview for mental status) score of 10, indicating moderate cognitive deficit (8-12), required limited assist of 1 with personal hygiene, extensive assist of 2 with toileting, dressing, and bed mobility. The resident was always incontinent of bowel and bladder. The resident had two pressure ulcers with pressure reducing devices in the wheelchair and on the bed. The resident was on a turning/ repositioning program. Had nutrition/ hydration interventions in place. Pressure ulcer care, application of dressing and ointment or medication.

The CAA (care area assessment) for pressure ulcers, dated 2/8/19, assessed the resident had two pressure ulcers both being treated with prisma (dressing that absorbs drainage and contains a low level of silver that aids in killing bacteria) and mepilex border (foam dressing) changed every other day.

The care plan, revised 3/12/19, advised staff the resident required assist of 1-2 with mobility, dressing, toileting, bed mobility, and transfers. To monitor, assess, and record wound measurements weekly. The resident had depression, and resistance to care. Staff advised

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 20 | F 686 | | |

to educate the resident and give explanations of care given, and keep consistency in care, timing and staff as much as possible.

The physicians order sheet, dated 11/28/18, advised staff the resident was to wear pressure relieving boots during the day, reposition every 2 hours, and out of his/her wheelchair every 2 hours.

A wound assessment note, on 11/6/18, identified a stage 2 pressure ulcer above the anal area measuring 0.25 by 1.3 cm (centimeters). At this time resident had in place pressure relieving devices in the wheelchair, a ROHO (specialized pressure reducing cushion), and in bed, a low air loss mattress. With last noted measurement, on 3/20/19, of 1 by 0.5 cm and 0.1 cm in depth (improved).

Physicians order sheet, dated 3/20/19, instructed staff to pack the above anal wound with promogran (a collagen), cover with foam dressing and change every other day and as needed.

Observation, on 04/01/19 at 08:40 am, revealed the resident sat at the dining room table in the wheelchair. At 09:00 am, the resident observed sitting in his/her wheelchair, eating am meal, at 09:21 am the resident is observed moving him/herself down the hall in the wheelchair. At 09:37 am the resident is observed sitting in the wheelchair in his/her room actively watching the TV (television), at 09:55 am the resident is observed sitting in the wheelchair watching the TV. At 10:09 am, the resident is observed in his/her own room watching the TV, at 10:25 am, the resident continues in the wheelchair watching TV. At 10:40 am, the resident is observed in the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 21 | F 686 | | |

wheelchair in his/her room watching the TV, at 10:55 am the resident continues to sit in the wheelchair watching the TV. At 11:10 am, the resident had been observed sitting up in the wheelchair for two and a half hours.
Staff informed at that time. Staff I stated that the resident refused to be repositioned. At 11:25 am, staff I entered the resident's room and offered to reposition the resident, he/ she refused offer of assistance to laydown in the bed or move to the recliner.

Interview, on 4/1/19 at 11:25 am, revealed the resident stated "yes" he/she was having pain to his/her buttocks, but declined to lay down in the bed or move to the recliner. At that time, staff I did not notify the charge nurse.

Interview, on 4/1/19 at 11;25 am, with licensed nursing staff C revealed staff I did not notify charge nurse of the residents refusal to lay down. Resident agrees to move to the recliner for staff C. Staff C goes to find help for position change of the resident. Staff C returned to inform the resident that he/ she will be put in the bed following lunch. The resident was then taken, in the wheelchair, to the dining room for the noon meal. Staff C stated the resident will be laid down right after the noon meal.

Observation, on 4/1/19 at 12:30pm, the resident observed sitting in the wheelchair (now for 3 hours and 20 minutes) in his/her room. Nursing staff F and I, use the lift to move the resident into the bed, they use caution with the residents limbs and head, so as to not harm the resident. Staff F was requested to assess the resident's buttocks and there was no redness noted, dressing to coccyx is clean, dry and intact.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 22 | F 686 | | |

Observation, on 4/1/19 at 2:05 pm, revealed staff C performed wound care to the resident's pressure ulcer above the anal area. Staff C washed his/ her hands and obtained supplies. Applied gloves while he/ she explained the procedure to the resident, uncovered the resident and opened the brief, removed the old dressing. Staff C obtained wound measurements of 1.5 by 0.3 cm, and 0.1 cm in depth. Wound was cleaned, and collagen was cut & placed in the wound, the wound was then covered. All with the same gloves in place.

Interview, on 4/2/19 at 3:40 pm, with staff A, revealed the resident had pressure relieving devices on the bed and in the wheelchair, frequent position changes, and protein supplements in place prior to the resident acquiring the most recent pressure ulcer above the anal region.

Interview, with staff N, revealed staff are educated and reviewed by competencies upon hire and annually for hand hygiene. Staff N states in-services are given monthly.

Interview, with staff U, reveals staff are educated, and that the correct procedure of glove use is to change gloves when moving from dirty to clean following hand hygiene.

Updated pressure ulcer policy, dated 5/23/16, advises staff a resident having a pressure ulcer receives the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from forming.

Updated hand hygiene policy, dated 2/12/19,

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 686 | Continued From page 23<br>advises staff indications for hand-washing before and after contact with fluids or excretions, mucous membranes, non intact skin, and wound dressings, even if hands are not visibly soiled. After removing gloves.<br><br>The facility failed to provide proper repositioning in a timely manner for the resident to promote healing and prevent development of further pressure ulcers. In addition, the facility failed to provide wound dressing treatments with proper hand hygiene to promote healing of the pressure ulcer and prevent infection. | F 686 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 91 residents, with 20 residents selected for review, including 6 residents reviewed for accidents. The facility reported 1 resident at risk for elopement on one hall with an automatic exit door with a non functioning key pad and alarm. Based on observations and interviews, the facility failed to ensure a door monitoring system to ensure this 1 residents did not exit the building without staff knowledge. Furthermore, the facility failed to provide appropriate interventions for 1 of the 6 residents reviewed (#47) who experienced a fall | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 689 | Continued From page 24 | F 689 | | |

during transfer from the wheelchair to the bed.

Findings included:

- Observation, on 4-3-19 at 10:30 am, on one hall, revealed one of the double wooden doors between the unit and hallway containing the exit door, was open and the automatic door to exit the building opened without the use of a keypad, and did not alarm when opened.

Interview with direct care staff G, on 4-3-19 at 10:30 am, revealed he/she did not know the exit door opened without the code, and did not alarm. Staff G stated maintenance would need to repair the door.

Interview, on 4-3-19 at 1:30 pm, with licensed nurse M revealed 1 resident at risk for elopement.

Interview, on 4-3-19 at 1:30 pm, with administrative nursing staff T, confirmed 1 resident at risk for elopement on this unit. Staff T stated the administrator would have an action plan for monitoring this door that opened without a code, and did not alarm when opened. Staff T stated the door did have a camera monitor and this displayed at the nurses' desk.

Interview, on 4-3-19 at 1:30 pm, with maintenance staff L, revealed the contractors that worked on the door on Friday, 3-29-19, disengaged the key pad and alarm to the exit door. Staff L stated he/she would connect the alarm to sound, and contacted the contractors to complete the maintenance of the door on 4-4-19. Staff L stated, after 8:00 pm. the doors automatically locked.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 689 | Continued From page 25 | F 689 | | |

Interview, on 4-3-19 with administrative staff W revealed staff monitored the 1 resident at risk for elopement on this unit, and the key pad functioned between the hours of 8:00 pm and 7:00 am. Staff provided an action plan, at that time, to ensure safety during the time of key pad inactivation, and nonfunctioning alarm system.

The facility policy for door monitoring, revised 12-10-08, advised staff until the electronic monitoring system is functional, team members working in the facility will implement a plan to ensure that no resident exits the building without the awareness of knowledge of nursing staff members by continuously monitoring each exit door visually.

The facility failed to maintain a door monitoring system on one exit door to ensure the 1 resident at risk for elopement did not exit the building without staff knowledge.

- The POS (Physician Order Sheet), dated 4-01-19, documented the resident had diagnoses which included: hallucinations (sensing things while awake that appear to be real, but the mind created) and cardiac arrhythmia (abnormal electrical activity in the heart).

The annual MDS (Minimum Data Set), dated 7-15-18, documented the staff assessment for cognition revealed the resident had severly impaired cognition. He/she rerquired extensive assistance of 2 for bed mobility and transfers and had limitation on both sides of the upper and lower extremities. The resident had one non-injury fall since and 2 or more injury (except major) falls since the prior assessment.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 689 | Continued From page 26 | F 689 | | |

The significant change MDS, dated 2-06-19, docuemnted the resident had severe impairment in cognition. He/she required extensive assistance of 2 for bed mobility and transfers, and had functional limitation in range of motion of upper and lower extremities. He/she had one injury fall (except major), and two or more non-injury falls since the prior assessment.

The CAA (Care Area Assessment) for falls was incomplete.

The care plan, dated 2-24-19, for falls, instructed staff the resident had a short attention span.

Reveiw of the fall assessments, dated 12-14-18, 12-17-18, and 1-16-19, revealed the resident was at a high risk for falls.

Nurses notes, dated 1-23-19, evidenced the resident fell while transfering him/herself from the wheelchair to the bed. Staff initiated an intervention to place body pillows for positioning in his/her bed (not an appropriate intervention for a fall during transfer).

On 4-02-19 at 3:16 p.m., licensed staff Y, stated an intervention needed to be initiated as soon as possible following a fall. Staff need to find the root cause of the fall to prevent further falls.

On 4-02-19 at 3:19 p.m., licensed staff Z, stated the intervention for body pillows on 1-23-19, was not an approprite intervention for the fall.

On 4-02-19 at 3:34 p.m., administrative nursing staff A, stated the fall intervention on 1-23-19 was not approrpiate.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 689 | Continued From page 27<br><br>The policy for resident assessment, dated 6-1-18, instructed staff to develop a care plan to describe services furnished to attain the resident's highest practicable physical, mental, ann psychosicial well being.<br><br>The facility failed to provide approrpiate fall interventions for this resident, to prevent further falls. | F 689 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§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.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(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;<br>(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<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore | F 690 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 690 | Continued From page 28 | F 690 | | |

continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 91 residents. The sample included 20 residents, including 3 sampled residents reviewed for urinary catheter (tube inserted into the bladder to drain urine into a collection bag). Based on interview, record review and observation, the facility failed to handle the catheter tubing and collection bag in a clean, sanitary manner to prevent infections, for 1 (#2) of the 3 residents reviewed.

Findings included:

- The POS (Physician Order Sheet), dated 3-20-19, documented resident #2 had diagnosis of BPH (benign prostatic hyperplasia), a non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency and urinary tract infections.

The quarterly MDS (Minimum Data Set), dated 12-14-18, documented the resident had a BIMS (Brief Interview for Mental Status) score of 3, indicating the resident had severely impaired cognition. He/she required extensive assistance of 2 for toileting and had an indwelling urinary catheter.

The admission MDS, dated 3-16-18, documented

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 690 | Continued From page 29 | F 690 | | |

the resident had a BIMS score of 8, indicating the resident had moderately impaired cognition. He/she required extensive assistance of 2 for toileting and had an indwelling urinary catheter.

The CAA (Care Area Assessment) for indwelling urianry catheter, dated 3-16-18, documented the resident had BPH with a lower urinary tract obstruction (blockage).

The care plan, dated 1-07-19, for urinary catheter, instructed staff to perform catheter care daily.

On 4-01-19 at 10:52 a.m., the resident rested in his/her bed with the catheter collection bag laying directly on the floor.

On 4-01-19 at 2:30 p.m., the resident rested in his/her bed with the catheter collection bag laying directly on the floor.

On 4-01-19 at 3:58 p.m., the resident rested in his/her bed with the catheter collection bag laying directly on the floor.

On 4-02-19 at 8:53 a.m., the resident ate breakfast in the dining room. The catheter tubing laid on the floor beneath the wheelchair.

On 4-02-19 at 9:15 a.m., direct care staff H stated there should be a hook on the bed frame to hang the catheter bag from, otherwise the bag would lay on the floor.

On 4-02-19 at 9:25 a.m., direct care staff K stated the catheter collection bag should not be on the floor without a dignity bag.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 690 | Continued From page 30<br>On 4-02-19 at 1:47 p.m., licensed nursing staff X stated the catheter collection bag should never be on the floor.<br><br>On 4-02-19 at 3:34 p.m., administrative nursing staff A stated the catheter bag should not be on the floor, at any time.<br><br>The facility policy for Catheter Care procedure, dated 6-1-18, lacked instruction to staff to ensure the catheter collection bag and tubing were kept off the floor to prevent cross contamination and the development of infections.<br><br>The facility failed to ensure staff handled this resident's catheter collection bag and tubing in a clean, sanitary manner, to prevent cross contamination and the development of infections. | F 690 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 880 | Continued From page 31 | F 880 | | |

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 identified under the facility's IPCP and the corrective actions taken by the facility.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 880 | Continued From page 32<br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 91 residents. Based on observations and interviews, the facility failed to ensure an effective infection prevention program to prevent the spread of infection during room cleaning of 1 isolation room, inappropirate glove use during incontinence care for 1 (#29) resident and resident laundry processing on 4 of the 5 hallways.<br><br>Findings included:<br><br>- Observation, on 4-2-19 at 10:30 am, with housekeeping/laundry staff P, revealed the facility contracted to an outside agency for laundry services. Observation of the unit service hallways, at that time, revealed covered carts containing clean laundry lined the wall in the hallways with dirty laundry and trash in covered barrels beside the clean laundry. Staff P stated the clean laundry rooms were kept locked and when the contracted agency delivered laundry they did not unlock the clean laundry room door, but left the laundry in the service hallway. Staff P confirmed the clean and soiled laundry should not be stored in the same hallway.<br><br>Observation, on 4-2-19 at 11:00 am, with housekeeping/laundry staff P, revealed the facility laundered resident slings for the lifts and | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 880 | Continued From page 33 | F 880 | | |

pressure relieving boots worn by residents, in two noncommercial high efficiency washers and utilized noncommercial dryers. Staff P stated staff used ordinary laundry detergent, and thought the water temperature was 170 degrees. Staff P stated if there was any isolation laundry it wound be washed separately, but then would be distributed to the general population.

Interview, on 4-2-19 at 11:00 am, with maintenance staff L, revealed the water temperature for the washing machines was monitored approximately every 6 months, and thought the last temperature in December 2018 was 170 degrees Fahrenheit.

Observation, on 4-2-19 at 11:00 am, revealed the water temperature of the water in the washing machine (placed on the Hot Water cycle) was 115 degrees Fahrenheit. Maintenance staff L adjusted the water heater temperature, at that time, however, subsequent temperatures did not increase above 115 degrees.

The facility policy for laundry services, last reviewed 2-19-19, advised staff linens will be stored and processed in a manner which will prevent odors, contamination of clean linen and spread of disease. The clean linen receiving, holding sorting and distribution areas that exist will be separate from the soiled linen area. Clean linen will be delivered to clean linen rooms. The policy lacked instruction regarding the proper water temperatures necessary for processing linens and resident care equipment soiled with blood and/or body fluids.

The facility failed to process laundry in a sanitary manner, including keeping clean and dirty laundry

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 880 | Continued From page 34 | F 880 | | |

and trash in separate areas, and ensure proper water temperatures for laundering of linens and resident care equipment in a sanitary manner to prevent the spread of infection amongst the residents.

- Observation, on 04/02/19 at 11:12 AM, revealed direct care staff F, applied gloves and removed resident #29's sweat pants that were wet with urine and the wet bed pad that was underneath the resident, removed the disposable brief, grabbed the package of wipes using the same gloves, and wiped the skin in the resident's peri area. Then, direct care staff F, grabbed a dry brief and placed under the resident with the same pair of gloves on, grabbed the wipe package, and provided further skin care. Then direct care staff G handed direct care staff F a tube of Periguard ointment and applied the ointment to the resident's peri area. Direct care staff F then removed the one glove used to apply the ointment, fastened the resident's clean disposable brief, placed a clean pair of sweatpants on the resident, placed on the resident's footwear, assisted the resident to sit on the side of the bed, placed a gait belt around the resident, and staff F and G transferred the resident to a wheelchair. Direct care staff F then removed the other glove, took the bags of linens and trash to the soiled utility room, then went to the nurses station. Direct care staff F then washed his/her hands at the sink available at the nurses desk after questioned when was hand hygiene performed.

The facility Hand Hygiene policy, revised 2/12/19, instructs the staff to perform hand-washing before and after contact with body fluids even if hands

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 880 | Continued From page 35 | F 880 | | |

are not visibly soiled, when moving form a contaminated body site to a clean body site during resident care, before and after contact with inanimate objects including medical equipment in the immediate vicinity of the resident, and after removing gloves.

The facility failed to perform hand hygiene during incontinence care to prevent cross contamination and reduce the transmission of infection to the residents.

-Observation, on 4/3/19 at 8:44 am, revealed custodial staff J, prepared to clean an isolation room. Staff J, donned clean gloves, took the facility spray cleaner (virex II 256), and sprayed the mattress, then wiped the mattress with a clean cloth, removed the mattress and sat it on the floor. Staff J removed dirty gloves, donned new gloves, placed the mattress back on the frame. Took off and disposed of the gloves, donned new gloves and entered the bathroom with powder cleaner (sun flo with bleach), sprinkled the powder cleaner into the toilet and sink. Took a clean cloth and wiped the tank and seat of the toilet and moved to wipe the sink with the same cloth. At that time, the surveyor requested staff J use a clean cloth on the sink. Staff J wiped the sink with a clean cloth. Staff J went out to the cart and changed gloves with no hand hygiene performed.

Interview, with custodial supervisor staff P, revealed he/she confirmed the cleaning procedure for an isolation room, proper use of hand hygiene with gloves, and in-services with staff regarding these.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 880 | Continued From page 36<br>The updated hand hygiene policy, dated 2/12/19, advised staff indications for hand-washing before and after contact with fluids or excretions even if hands are not visibly soiled and after removing gloves.<br><br>The facility failed to provide appropriate cleaning services of an isolation room or proper hand hygiene to prevent the cross contamination and development and/ or spread of communicable disease and infection. | F 880 | | |
| F 909 SS=E | Resident Bed<br>CFR(s): 483.90(d)(3)<br><br>§483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible.<br>This REQUIREMENT is not met as evidenced by:<br>The facility reported a census of 91 residents. Based on observation and interview, the facility failed to ensure properly fitting mattresses and bed frames were provided to 14 resident beds to prevent entrapment and/or improper positioning.<br><br>Findings included:<br><br>- Observation, on 4-3-19 at 11:00 am, with maintenance staff L and housekeeping staff P, revealed the following beds with gaps between the mattress and headboard or footboard. Six resident beds on hall 400 had a 6" gap between the head board and mattress. | F 909 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175516 | A. BUILDING _____ B. WING _____ | 04/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KANSAS VETERANS HOME | 1220 WORLD WAR II MEMORIAL DRIVE WINFIELD, KS 67156 |

| (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 909 | Continued From page 37<br>One resident bed had a 12" (inch) gap between the footboard and mattress. Four resident beds on 500 hall had a 6" gap at the head of the bed, and one resident bed had an 8" gap at the head of the bed. Two resident beds on 200 hall had a 5" gap at the foot, and 5" gap at the head.<br><br>Interview with maintenance staff L revealed nursing staff may be replacing the mattresses without measuring the frame.<br><br>The facility policy for bed rail procedures, revised 8-12-02, advised staff to make sure the mattress fits the bed sufficiently to not leave space for the resident to become trapped between the mattress and the rail.<br><br>The facility failed to ensure properly fitting mattresses to bedframes to prevent possible entrapment and or improper positioning. | F 909 | | |