STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175379	A. BUILDING _____ B. WING _____	C 02/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENNONITE FRIENDSHIP COMMUNITIES INC	600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505

(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 complaint investigations KS00138542, KS00138569 and KS00138497. The 2567 was electronically sent to the facility on 3/6/19.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 103 residents with 5 selected for sample. Based on observation, interview and record review, the facility failed to ensure 1 of 5 residents received adequate supervision to prevent accidents when staff left the resident alone on the toilet, unattended, for prolonged periods of time. (Resident #3) Findings included: - Resident #3's clinical record included a diagnosis list which identified the resident with multiple medical diagnoses, including severe intellectual disabilities (disability characterized by a significantly below-average score on a test of mental ability or intelligence and by limitations in the ability to function in areas of daily life, such as communication, self-care, getting along in social situations and school activities), lack of coordination, difficulty in walking, muscle weakness, abnormal posture, and developmental	F 689		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 speech disorder. The 11/17/18 Quarterly MDS (Minimum Data Set) identified the resident with long and short term memory problems, moderately impaired decision making abilities, the inability to ambulate, impaired balance in all areas and only able to stabilize without staff assistance, and then need for extensive assistance of one staff for toileting. The current undated care plan directed staff to transfer resident #3 with assistance of one staff and a gait belt for toileting. The facility provided a copy of the investigation into a 2/20/19 incident in which Direct Care Staff F allegedly placed resident #3 on the toilet at approximately 10:00 a.m.. Staff F then went on a break and left the resident seated on the toilet. The resident remained seated on the toilet until approximately 12:30 p.m. when staff failed to locate him/her at lunch time and searched for him/her. On 2/21/19, staff added an intervention to the current care plan which directed staff to stay with the resident while he/she sat on the toilet because the resident no longer used the call light consistently. During an observation on 2/28/19 at 8:40 a.m., Direct Care Staff G and Direct Care Staff H prepared to transfer resident #3 from the wheelchair to the toilet. The resident lacked the ability to verbalize his/her needs but could follow simple commands. The resident communicated by making noises and gesturing. Staff G and H remained with the resident while he/she sat on the toilet.	F 689		

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F 689	Continued From page 2 During an interview on 2/28/19 at 8:50 a.m., Direct Care Staff G reported resident #3 lacked the ability to use the call light in the bathroom and could not verbalize to call for help. According to Staff G, staff "forgot" the resident on the toilet "about a week ago" and the resident remained on the toilet for "a couple of hours." After the incident, Staff G reported staff were instructed to stay with the resident whenever he/she was on the toilet. During an interview on 2/28/19 at 8:55 a.m., Direct Care Staff H reported staff left the resident alone on the toilet again "last night" (2/27/19) on the 2nd shift. According to Staff H, the charge nurse at "report" that morning reminded them of the need to remain with the resident while he/she sat on the toilet because staff the night before left the resident alone. During an interview on 2/28/19 at 10:30 a.m., Administrative Staff A confirmed an incident occurred again on the second shift on 2/28/19 when staff left the resident unattended on the toilet. According to Staff A, staff who worked the second shift all denied placing resident #3 on the toilet. Staff investigated the incident and determined the resident remained alone on the toilet for a time period of 15-30 minutes. The facility failed to provide resident #3 with adequate supervision to prevent accidents when staff left the resident unattended on the toilet for an estimated 2 1/2 hour time period on one occasion. Staff then determined the resident required constant monitoring while on the toilet and updated the care plan with that information. After revision of the care plan, staff again left the resident unattended on the toilet.	F 689		
F 690	Bowel/Bladder Incontinence, Catheter, UTI	F 690		

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F 690 SS=D	Continued From page 3 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must 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 had a census of 103 residents with 5 selected for sample. Three sampled residents had indwelling bladder catheters (tube placed in	F 690		

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F 690	Continued From page 4	F 690		

the bladder to drain urine into a collection bag). Based on observation, interview and record review, the facility failed to ensure 2 of 3 residents with catheters received appropriate care and services (catheter care) to prevent urinary tract infections. (Residents #1, #5)

Findings included:

- Resident #5's clinical record included a diagnosis list which identified the resident with multiple medical diagnoses included urinary retention (lack of ability to urinate and empty the bladder).

The 12/30/18 Quarterly MDS (Minimum Data Set) identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 3), and the presence of an indwelling bladder catheter (tube placed in the bladder to drain urine into a collection bag).

The current undated care plan noted the presence of urinary catheter, subsequent risk for development of urinary tract infections and history of urinary tract infections. According to the care plan, the resident "depends on staff for management of the catheter."

Physician's orders included a 1/31/19 order to "provide catheter care every shift twice daily."

During an observation on 2/7/19 at 4:10 p.m., Direct Care Staff I prepared to provide catheter care to resident #5. Staff I assisted the resident to a standing position in front of his/her recliner. After exposing the resident's frontal genital area with him/her in a standing position, Staff I used disposable wipes to clean the tubing of the catheter. Staff I used multiple wipes to clean

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F 690	Continued From page 5	F 690		

different sections of the tubing. Staff I failed to visualize the insertion site of the catheter (the point where the catheter tubing enters the body) and to clean that area thoroughly. The positioning of the resident in a standing position made visualization of the insertion site difficult.

During an interview on 2/7/19 at 4:20 p.m., Direct Care Staff I confirmed he/she failed to visualize and clean the insertion point of the catheter.

The facility's 08/18 "Catheter Care" policy and procedure directed staff to "Gently clean the urinary meatus [where urine exits the body] using a circular motion moving from middle toward the outside with a wet wipe or soap and water."

The facility failed to provide resident #5 with appropriate catheter cleaning, including cleaning of the insertion point of the catheter, to prevent urinary tract infections.

- Resident #1's clinical record included a diagnosis list which identified the resident with hydronephrosis (a condition in which the affected kidney swells due to urine failing to drain from the kidney to the bladder), neuromuscular dysfunction of the bladder (condition in which nerves/muscles fail to function properly within the bladder) and cerebral palsy (a progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth).

The 2/8/19 Quarterly MDS (Minimum Data Set) identified the resident with no memory problems, total dependence on staff for personal hygiene, and use of an indwelling bladder catheter (tube placed in the bladder to drain urine into a collection bag).

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F 690	Continued From page 6 The current undated care plan noted the presence of an indwelling catheter and the subsequent risk of urinary tract infections. Physician's orders included a 10/16/18 order for "Catheter care every shift." During an observation on 2/7/19 at 2:00 p.m., Direct Care Staff D and Direct Care Staff E assisted resident #1 on and off the bedpan while the resident lay in bed. After the resident had a bowel movement, Staff D assisted the resident to a supine (lying on the back) position and prepared to complete catheter care. Staff D used disposable wipes to clean the catheter tubing. Staff D failed to visualize and clean the catheter insertion site (the point where the catheter tubing enters the body). During an interview on 2/28/19 at 9:00 a.m., Administrative Nurse B reported staff should clean the catheter insertion site as part of routine catheter care. The facility's 08/18 "Catheter Care" policy and procedure directed staff to "Gently clean the urinary meatus [where urine exits the body] using a circular motion moving from middle toward the outside with a wet wipe or soap and water." The facility failed to provide resident #1 with appropriate catheter cleaning, including cleaning of the insertion point of the catheter, to prevent urinary tract infections.	F 690		
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	F 880		

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F 880	Continued From page 7 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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	F 880		

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F 880	Continued From page 8 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This Requirement is not met as evidenced by: The facility had a census of 103 residents with 5 selected for sample. Based on observation, interview and record review, the facility failed to take appropriate infection control precautions (changing contaminated gloves after staff came in contact with fecal matter) to prevent infections for 1 of 5 residents. (Resident #1) Findings included: - Resident #1's clinical record included a 2/8/19 Quarterly MDS (Minimum Data Set) which identified the resident with total dependence on staff for toileting and personal hygiene. According to the MDS, the resident also utilized an indwelling bladder catheter (tube placed in the bladder to drain urine into a collection bag).	F 880		

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F 880	Continued From page 9	F 880		

The undated care plan noted resident #1's bowel incontinence and directed staff to change the resident's brief as necessary.

During an observation on 2/27/19 at 2:00 p.m., Direct Care Staff D and E placed resident #1 on the bedpan as the resident lay in bed. The resident had an indwelling bladder catheter in place at the time of the observation. Resident #1 had a bowel movement on the bedpan. After Staff D and E rolled the resident off the bedpan and onto his/her left side, Staff D used disposable wipes to clean fecal material from the rectal/perineal area. Staff D wore gloves during the cleaning process. After completion of rectal/perineal cleaning, Direct Care Staff D failed to remove the contaminated gloves. Staff D and E then rolled the resident back onto his/her back and Staff D provided catheter care (cleaning of the catheter tubing) with the contaminated gloves still in place. Direct Care Staff D removed the contaminated gloves after completion of catheter care.

During an interview on 2/28/19 at 9:30 a.m., Administrative Nurse B reported staff completed catheter care competencies within recent months and staff should know to change contaminated gloves after contact with fecal matter and prior to completion of catheter care.

The facility's 6/15/18 "Standard Precautions - Nursing Infection Control" policy and procedure directed staff to "Wear gloves when it can be reasonably anticipated that contact with blood or potentially infectious materials could occur.....Remove gloves after contact with a resident using proper technique to prevent hand contamination...Change gloves during resident care if the hands will move from a contaminate

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F 880	Continued From page 10 area to a clean area...." The facility failed to take appropriate infection control precautions (changing contaminated gloves after staff came in contact with fecal matter) to prevent infections while providing care to resident #1.	F 880		