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 _____	03/09/2023

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 a Health Resurvey and Complaint Investigation # 176204. This 2567 was electronically sent on 03/15/23.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		

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
	175379	A. BUILDING _____ B. WING _____	03/09/2023

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F 755	Continued From page 1	F 755		

order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 69 residents with 17 residents sampled, that included five residents sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to follow physician's orders for Resident (R)12, related to physician ordered insulin. This failure placed the resident at risk for adverse effects related to medication use.

Findings included:

- R12's diagnoses from the "Electronic Health Record" (EHR) included diabetes mellitus, type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and dementia (progressive mental disorder characterized by failing memory, confusion).

The 10/24/22 quarterly "Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of 14, indicating intact cognition. R12 received insulin injections daily in the seven-day look-back period.

The 01/22/23 annual MDS documented the resident had a BIMS of 15, indicating intact cognition. R12 received insulin injections daily in the seven-day look-back period.

The 01/22/23 "Care Area Assessment" (CAA) lacked documentation related to insulin use.

The 03/09/23 "Care Plan" lacked documentation specific to insulin administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 2	F 755		

The "Electronic Health Record" (EHR) included the following physician orders:

1. Novolog Flexpen insulin 100 unit/mL (milliliter) - 10 units subcutaneous (an injection beneath the skin) three times daily, with meals, ordered 01/20/17.

2. Accucheck (a device to obtain the resident's blood sugar level) four times daily before each meal and at bedtime. Notify the physician if the resident's blood sugar was below 50 and/or over 400 milligrams/deciliter (mg/dL).

Review of the physician's orders lacked an order with blood sugar parameters to withhold medication and notify the physician.

Review of the 02/2023 to 03/2023 "Medication Administration Record" (MAR) revealed the following concerns:

1. On 02/07/23 at 04:49 PM, Novolog Flexpen was not administered with the resident's blood sugar documented of 97 mg/dL.

2. On 02/26/23 at 04:51 PM, Novolog Flexpen was not administered with the resident's blood sugar documented of 91 mg/dL.

3. On 03/02/23 at 12:06 PM, Novolog Flexpen was not administered with the resident's blood sugar documented of 112 mg/dL.

4. On 03/03/23 at 12:55 PM, Novolog Flexpen was not administered with the resident's blood sugar documented of 133 mg/dL.

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 _____	03/09/2023

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

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F 755	Continued From page 3 5. On 03/07/23 at 10:50 AM, Novolog Flexpen was not administered with the resident's blood sugar documented of 98 mg/dL. The "Progress Notes" lacked documentation related to the physician notification of insulin having been held with rationale. On 03/09/23 at 11:51 AM, Licensed Nurse (LN) G revealed that there is a physician order to notify the physician if the blood glucose level was below 50 mg/dL or above 400 mg/dL and verified there was no order with parameters to hold the resident's insulin dose(s). Furthermore, LN G stated that if a nurse felt the insulin should be held, then staff should notify the physician for an order clarification. On 03/09/23 at 01:16 PM, Administrative Nurse D revealed that if R12's blood sugar was below 100 mg/dL, nurses would hold the scheduled insulin dose and feed the resident. Additionally, Administrative Nurse D revealed that no order exists in the EHR for staff to have parameters to hold R12's insulin dose(s). The facility's 06/01/18 "Medication Administration" policy documented that staff should execute "hold" orders only with a physician's order. The facility failed to follow physician's orders for R12 related to insulin not being administered as the physician ordered. This placed the resident at risk for adverse effects related to medication use.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756		

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 _____	03/09/2023

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F 756	Continued From page 4	F 756		

§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

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

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 69 with 17

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 _____	03/09/2023

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

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F 756	Continued From page 5	F 756		

residents in the sample that included five residents reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to follow up in a timely manner on the recommendations made by the pharmacist for Resident (R)12. This caused the resident to receive unnecessary medications for a total of 19 days.

- R12's diagnoses from the "Electronic Health Record" (EHR) included diabetes mellitus, type 2 (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) and major depressive disorder (a major mood disorder).

The 10/24/22 quarterly "Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) of 14, indicating intact cognition. R12 received an antipsychotic (class of medications used to treat psychosis [any major mental disorder characterized by a gross impairment in reality testing] and other mental emotional conditions) and antidepressant medications (class of medications to treat depression [abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness]) daily in the seven-day look-back period.

The 01/22/23 annual MDS documented a BIMS of 15, indicating intact cognition. R12 received antipsychotic and antidepressant medications daily in the seven-day look-back period.

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 _____	03/09/2023

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F 756	Continued From page 6	F 756		

The 01/22/23 "Psychotropic Care Area Assessment" (CAA) documented R12 resident received antipsychotic and antidepressant medications daily in the seven-day look-back period.

The 03/09/23 "Care Plan" instructed staff to review pharmacy consultant recommendations and to follow up as indicated.

The "Electronic Health Record" (EHR) included the following physician orders:

1. Desvenlafaxine (an antidepressant medication) 50 mg (milligrams) to be given orally, one tablet by mouth every morning for "psychotropic regimen", ordered 01/20/17.

2. Risperidone (an antipsychotic medication) 1 mg to be given orally, twice daily, for bipolar disorder, ordered 01/20/17.

3. Trazodone (an antidepressant medication) 50 mg to be given orally, daily for insomnia/depression, ordered 01/20/17.

Review of the facility's pharmacy consultant's reviews revealed the following concerns:

1. On 06/29/22, the consultant pharmacist requested an order with parameters for abnormal blood sugar readings to be communicated to the physician. The physician ordered to contact the physician if the resident's blood sugar readings was under 50 or over 400 milligrams/deciliter (mg/dL). The physician signed the pharmacy consult on 07/18/22, a total of 19 days after the request was made.

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 _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 7	F 756		

2. On 08/31/22, the consultant pharmacist requested a reduction in dose(s) for the resident's psychotropic medications (desvenlafaxine, risperidone and/or trazodone). The physician ordered for the Desvenlafaxine to be reduced from 100 mg daily to 50 mg daily on 09/19/22, a total of 19 days staff administered the higher dosage.

3. On 08/31/22, the consultant pharmacist had a request related to famciclovir (antiviral medication) 250 mg for the resident's diagnosis of "herpes simplex" (a viral infection marked by watery blisters on the skin or mucous membranes of the lips, mouth, face, or genitals), whether the physician wanted the medication continued or discontinued. due to possible side effects of nausea and diarrhea. The physician discontinued the famciclovir on 09/19/22, a total of 19 days after the request was made.

The "Progress Notes" lacked documentation related to physician notification from staff about pharmacy recommendations.

On 03/09/23 at 11:51 AM, Licensed Nurse (LN) G revealed that when the pharmacist would send recommendations, the process was for Administrative Nurse D to send them to the charge nurse of each unit, the charge nurse(s) then send them to the respective physician, the time frame for completion from the physician should be approximately two to three days, if the nurse(s) doesn't get a response in a few days, the request should be resent to the physician. Furthermore, 19 days is too long to wait without resolution of the pharmacist's recommendation.

On 03/09/23 at 01:16 PM, Administrative Nurse D

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 _____	03/09/2023

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

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F 756	Continued From page 8	F 756		

stated that nurses should be expected to send the pharmacist's recommendation to the physician and to attempt contact if no response in three to five days. Additionally, physicians expected to respond to the pharmacist's recommendations in three to five days. Administrative Nurse D stated 19 days was too long to wait for resolution of pharmacist's recommendations.

The facility's 11/2019 "Medication Review" policy documented that the licensed pharmacist would report any irregularities to the attending physician, medical director and the director of nursing (DON). The physicians and the director of nursing should provide timely responses to irregularities identified during the medication regimen review (MRR).

The facility's 11/2019 "Pharmacist Notification to Physician Procedure" policy documented the following:

1. During the monthly MRR, the pharmacist would provide reports/recommendations to the DON and the medical director.

2. The charge nurse would send recommendation to the physician within three business days (via fax, in-person delivery or placed in a folder for physician to review during rounding).

3. If no response from the physician after seven business days, the recommendations would be re-faxed and the charge nurse would contact the physician via telephone to provide follow up.

The facility failed to follow up in a timely manner

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 _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 9 on the recommendations made by the pharmacist for R12. This caused the resident to receive unnecessary medications for 19 days.	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility reported a census of 69 residents with one central kitchen. Based on observation, interview, and record review, the facility failed to store foods safely and sanitary by the staff's failure to date and reseal open food items and the failure to use gloves appropriately when serving food. Findings included: - On 03/07/23 at 07:47 AM, observation of the	F 812		

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 _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 10	F 812		

refrigerator located in the food service area of the kitchen revealed an approximately 3-inch stack of sliced cheese wrapped in plastic wrap. The cheese had no open date or use by date written on the packaging. Dietary staff CC verified the opened, undated cheese and disposed the cheese.

On 03/07/23 at 08:05 AM, dietary staff DD observed passing room trays on 100 hall. After giving a resident her tray, she assisted the resident with setting up her food. She picked up the resident's toast, butter, and jelly with the same gloved hands used to pass out all room trays on the food cart.

On 03/08/23 at 01:05 PM, dietary staff BB reported she had been told by her staff about the cheese found on initial tour and had reminded her staff about dating all food items prior to returning to storage. (Cold or dry storage). She also reported teaching the dietary staff about proper food handling and glove usage but would have to do more education.

Review of the facility's Policy named "Food Storage Dry, Refrigerated, and Frozen" dated 2020, revealed all food items would be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded.

Review of the facility's Policy named "Use of Gloves in Food Service" dated 11/2017, revealed gloves used to handle food are for single use only and will not be washed or re-used. Gloves will be used for handling of ready to eat foods if food is to be touched and utensils not used.

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 _____	03/09/2023

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 812	Continued From page 11 The facility failed to store foods safely and sanitary by the staff's failure to date and reseal open food items and the failure to use gloves appropriately when serving food.	F 812		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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	F 880		

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 _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880		

communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of 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 reported a census of 69 residents which included a sample of 17 residents. Based on observation, interview, and record review, the facility failed to handle, store, and process linen and biohazard waste (infectious waste deemed a

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 _____	03/09/2023

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 880	Continued From page 13	F 880		

threat to public health or environment) in a manner to prevent the cross contamination and spread of infection in resident (R)69's isolation room and one of four soiled utility rooms.

Findings included:

- On 03/08/23 at 11:00 AM, observed a red bag lined container, used for disposal of trash/used PPE in resident's (R)69's isolation room lacked a cover to contain the overflowing used personal protective equipment (PPE). Maintenance staff FF and GG PPE and entered the resident's room. After completing a maintenance task in the room, Maintenance Staff FF and GG removed their used/soiled PPE, placed it in the container, and shoved it down in the container with their ungloved hand. They agreed the used PPE should have been emptied and the lid closed to prevent cross contamination and the spread of infection. Staff FF and GG reported the housekeeping staff, and/or the nursing staff should remove the used PPE bags and blue soiled linen from the isolation rooms when full and take them to the soiled utility rooms for processing of linen and biohazardous waste. Furthermore, they confirmed the facility ran out of Bio-hazardous boxes due to supply issues and the increase of residents with COVID.

On 03/08/23 at 11:15 AM, Housekeeping Staff V stated staff used red bags to dispose of trash from the isolation rooms and should be placed in the soiled utility room in a biohazardous box for disposal. The blue bags used to contain the soiled linens from the isolation rooms. She confirmed the housekeeping staff would pick up the soiled linen from the soiled utility room if the certified nurse aides (CNA) did not take the blue

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 _____	03/09/2023

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 880	Continued From page 14	F 880		

bags to the laundry from the isolation rooms.

On 03/08/23 at 11:25 AM, Licensed Nurse (LN) H confirmed red bags were to be used to dispose of trash from the isolation rooms and should be placed in the soiled utility room in a biohazardous box for disposal. The blue bags were to be used to contain the soiled linens from the isolation rooms. She confirmed the housekeeping staff would pick up the soiled linen from the soiled utility room if the CNA's did not take the blue bags to the laundry from the isolation rooms.

On 03/08/23 at 11:27 AM, during the tour of 300 hall's soiled utility room with LN I, observation revealed three full plastic bags laid directly on the floor. LN I reported blue bags contained soiled linen from isolation rooms and one red bag which contained trash/biohazardous waste from an isolation room. She stated bags with soiled linen nor trash should not be placed directly on the floor. The blue bags of linen should be in a linen cart and the trash should be contained in a biohazardous carton for disposal.

On 03/08/23 at 11:33 AM, Housekeeping staff V verified three full plastic bags laid directly on the floor in the soiled utility room on 300 hall. She reported soiled linens were to be delivered to the laundry at the end of each shift by the certified nurse aides (CNAs). The other linen rooms were bigger and had barrels with lids, however "this one was so small it does not have room for barrels like the other halls". The linen and trash should be in contained barrels and not on the floor to prevent the spread of infection.

On 03/08/23 at 12:21 PM, CNA M confirmed the soiled linen from the isolation rooms should be

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F 880	Continued From page 15	F 880		

contained in blue bags and the trash went in the red bags for transport to the soiled utility rooms on each unit. She stated the red bagged trash should then be placed in the biohazardous container for disposal and the blue bags should be placed in the closed laundry cart or barrel to prevent cross contamination and the spread of infection. Bagged trash or linen should never be placed directly on the floor in the soiled utility room.

03/09/23 10:06 AM, Administrative Nurse D verified the isolation rooms should have a red bag in a closed container for trash disposal of biohazardous waste and a container linen with a blue bag for soiled linen. The trash and linen should be in a closed container to prevent cross contamination and the spread of infection. The red and blue bags should be overfilled but closed and stored appropriately off the floor.

The facility policy "Infection Prevention and Control Plan," dated 06/2022, documentation included it is the policy of the facility to 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 disease and infections. Laundry and direct care staff shall handle, store process, and transport linens to prevent the spread of infection.

The facility failed to handle, store, and process linen and biohazard waste in a manner to prevent the cross contamination and spread of infection in resident (R)69's isolation room and one of four soiled utility rooms.