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	175559	A. BUILDING _____ B. WING _____	12/07/2023

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WESTERN PRAIRIE SENIOR LIVING LLC	510 E SAN JACINTO AVENUE ULYSSES, KS 67880

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey L7GZ11. This 2567 was electronically sent to the facility on 12/11/23.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: The facility census totaled 39 residents with 12 included in the sample. Based on observation, interview and record review the facility failed to complete an accurate Minimum Data Set (MDS) for two sampled residents including, Resident (R)7 by the failure to include the resident's pressure ulcer and (R) 29's indwelling urinary catheter use on the MDS. Findings included: - R7's pertinent diagnoses from the signed Physician's Order dated 11/23/23 included Alzheimer's disease with late onset (progressive mental deterioration characterized by confusion and memory failure), severe dementia (progressive mental disorder characterized by failing memory and confusion), with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).	F 641		

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 641	Continued From page 1 The 7/17/23 Significant Change in Status MDS revealed a BIMS of 99 indicating severely impaired cognition. R7 required extensive assistance of one to two staff for all cares and was always incontinent of bowel/bladder. The assessment indicated no current pressure ulcer and the resident was not at risk for a pressure ulcer. The resident had pressure relieving devices on his bed/chair with a turn/reposition program. The 09/14/23 readmission "Significant Change in Status Minimum Data Set" (MDS) revealed the resident as unable to complete a Brief Interview for Mental Status (BIMS) with memory problems and severely impaired cognition. R7 required total dependence of two staff for all cares and was always incontinent of bowel/bladder. The assessment indicated no current pressure ulcer and the resident not at risk for a pressure ulcer. The resident had pressure relieving devices on his bed/chair with a turn/reposition program. The facility failed to include a coccyx wound/pressure ulcer identified by staff upon acute care readmission on 09/07/23, for an accurate MDS. The 09/14/23 "Care Area Assessment" (CAA) documented: Pressure Ulcer CAA-Resident had Alzheimer's and dementia. She was non-verbal and rarely understood or able to understand others. Staff need to pay attention to non-verbal cues and anticipate needs/wants. She was incontinent and requires staff assistance for all Activities of Daily Living (ADLs) including incontinent brief check and change. Staff need to reposition the resident every two hours. The resident has a pressure reducing mattress and cushion to the wheelchair. The record lacked documentation of a coccyx wound/pressure ulcer.	F 641		

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F 641	Continued From page 2	F 641		

The 12/06/23 "Care Plan" lacked instructions related to the resident's coccyx wound, wound prevention, or wound treatment when the resident readmitted to the facility with the wound/pressure ulcer on 09/07/23.

The Electronic Health Records (EHR) "Physician Orders" dated 11/03/23 documented instructions to staff to apply a Mepilex dressing to the resident's coccyx and to change it one time a day, every three day(s) and as needed PRN. Staff to monitor the coccyx dressing site each shift.

The "Treatment Administration Record" (TAR) documented 11/03/23 to 12/06/23 the staff changed of the dressing to the resident's coccyx and dressing checks of the resident's coccyx dressing. This record lacked documentation of the coccyx wound/pressure ulcer care prior to 11/03/23. The wound was first documented on readmission to the facility from acute care on 09/07/23 as a coccyx slit.

The "Progress Notes" dated 09/07/23 at 04:30 PM, documented the resident re-admitted from acute care with Hospice services at 03:30 PM. Hospice in the facility to assess the resident. Skin assessment revealed an open slit to the resident's coccyx. Staff changed the Mepilex dressing to the resident's coccyx pressure ulcer. The note lacked further description or measurement of the area.

R7's EHR lacked weekly documentation with description of the coccyx wound/pressure ulcer.

On 9/14/2023 a Braden Scale for Predicting Pressure Sore Risk identified the resident with a

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score of 12 (high risk).

On 11/03/23 at 06:29 AM, a Skin/Wound Note documented R1 had a two centimeter (cm) open area to the coccyx. The surrounding skin was within normal limits. Staff applied a Mepilex dressing and notified the wound care nurse.

The EHR reviewed, revealed no further documentation with description or measurements of the wound.

Review of Hospice progress notes revealed:
On 09/07/23 documented skin as "progressing" without additional documentation found.
On 09/21/23 documented skin as "progressing".
On 10/05/23 documented skin as "progressing".
On 10/19/23 documented no skin integrity issues.
On 11/02/23 documented no skin integrity issues.
On 11/16/23 documented 1 cm area of concern to coccyx.

Observations on 12/06/23 from 08:30 AM to 10:46 AM, (two hours and 16 minutes) revealed the resident sat in her recliner with feet elevated and without staff offering the resident a change of position.

On 12/06/23 at 10:46 AM Certified Nursing Assistant (CNA) G, CNA H and Licensed Nurse (LN) C entered the resident's room and assisted R7 onto the bed. The staff rolled R7 to her right side, with clothing removed and loosened the brief. The staff removed the resident's brief. LN C removed the border gauze dressing to the resident's coccyx. CNA G then performed incontinence care with R7's skin on the bottom/coccyx area appearing red in color. LN C provided the wound measurement as one cm x

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F 641	Continued From page 4	F 641		

one half cm. She then dated/initialed the dressing after she applied it to the wound.

Interview on 12/06/23 at 10:58 AM with CNA G revealed the staff completed every two-hour check and change of the resident for incontinence.

On 12/06/23 at 11:08 AM LN C reported she identified the resident's coccyx wound as a pressure wound that would open and close but stated that hospice was managing the wound. LN C stated she did a weekly skin assessment on all residents with wounds. LN C reported the wound was closed on 11/28/23 so no wound assessment was completed on that date. LN C reported she was not on duty when the resident readmitted from acute care and staff did not notify her of the resident's wound. The floor nurses were responsible for inputting the weekly skin assessment for residents with their showers.

On 12/07/23 at 11:30 AM Administrative Nurse F confirmed the MDS completed on 09/14/23 was inaccurate by not including the resident's pressure ulcer on the assessment.

On 12/07/23 at 12:22 PM Administrative Nurse B reported she expected the MDS, care plans and weekly skin/wound assessments to be accurate and completed.

A policy for MDS assessments was requested on 12/07/23. The facility used the RAI manual as reference per facility staff.

The facility failed to complete an accurate Minimum Data Set (MDS) for R7 by the failure to include the resident's pressure ulcer on the

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F 641	Continued From page 5	F 641		

assessment.

- The Electronic Health Records (EHR) documented R29 had the following diagnoses that included pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral region (small triangular bone at the base of the spine) and urinary tract infection (UTI - an infection of the lower urinary tract including the bladder and urethra [the tube that carries urine from the bladder to the outside of the body]).

The 09/07/23 "Admission Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 15, indicating intact cognition. The assessment documented R29 did not have an indwelling urinary catheter (insertion of a catheter into the bladder to drain the urine into a collection bag).

The 09/07/23 "Care Area Assessment" (CAA) documented R29 had an indwelling catheter to promote wound healing.

The "Care Plan" updated 09/20/23, documented R29 required a urinary catheter, and instructed staff to perform catheter care each shift and as needed.

The "Physician Orders" documented 08/23/23 to continue the Foley catheter on admission.

The "Treatment Administration Record" (TAR) from 8/31/23 to 12/08/23 documented indwelling catheter care performed each shift.

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F 641	Continued From page 6	F 641		

The EHR documented the following:

On 8/31/23 the EHR's -"Bowel and Bladder Assessment" documented R29 had a urinary catheter.

Review of the progress notes revealed on 09/02/23, staff inserted a urinary catheter into the resident. On 09/04/23, R29's urinary catheter came out.

On 09/06/23, R29's urinary catheter slipped out with fully inflated bulb during wound care.

On 12/06/23 at 01:06 PM, Administrative Nurse F revealed that corporate personnel complete sections of the MDS and confirmed the MDS as inaccurate.

On 12/07/23 at 01:18 PM, Consultant Nurse I confirmed the MDS was inaccurate. The expectation was that assessments were to be accurate per the guidelines of the "Resident Assessment Instrument" (RAI manual is an assessment that helps facility staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan).

On 12/07/23 at 01:40 PM, Administrative Nurse B revealed that her expectation was for all assessments, including the MDS assessments, to be accurate.

The facility's MDS policy dated 11/28/17, documented that residents would receive an accurate assessment reflective of the resident's status at the time of the assessment by staff who were qualified to assess and knowledgeable

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F 641	Continued From page 7 about the resident's status. The facility failed to accurately assess the MDS for R29 related to indwelling catheter. This placed the resident at risk for uncommunicated care needs including catheter care.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		

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desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 39 residents with 12 included in the sample. Based on observation, interview and record review the facility failed to develop a comprehensive care plan for Resident (R)7 by the failure to include the resident's pressure ulcer.

Findings included:

- R7's pertinent diagnoses from the signed Physician's Order dated 11/23/23 included Alzheimer's disease with late onset (progressive mental deterioration characterized by confusion and memory failure), severe dementia (progressive mental disorder characterized by failing memory and confusion), with agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

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F 656	Continued From page 9	F 656		

The 7/17/23 Significant Change in Status MDS revealed a BIMS of 99 indicating severely impaired cognition. R7 required extensive assistance of one to two staff for all cares and was always incontinent of bowel/bladder. The assessment indicated no current pressure ulcer and the resident was not at risk for a pressure ulcer. The resident had pressure relieving devices on his bed/chair with a turn/reposition program.

The 09/14/23 readmission "Significant Change in Status Minimum Data Set" (MDS) revealed the resident as unable to complete a Brief Interview for Mental Status (BIMS) with memory problems and severely impaired cognition. R7 required total dependence of two staff for all cares and was always incontinent of bowel/bladder. The assessment indicated no current pressure ulcer and the resident not at risk for a pressure ulcer. The resident had pressure relieving devices on his bed/chair with a turn/reposition program. The facility failed to include a coccyx wound/pressure ulcer identified by staff upon acute care readmission on 09/07/23, for an accurate MDS.

The 09/14/23 "Pressure Ulcer Care Area Assessment" (CAA) documented the resident had Alzheimer's and dementia. She was non-verbal and rarely understood or able to understand others. Staff need to pay attention to non-verbal cues and anticipate needs/wants. She was incontinent and requires staff assistance for all Activities of Daily Living (ADLs) including incontinent brief check and change. Staff need to reposition the resident every two hours. The resident has a pressure reducing mattress and cushion to the wheelchair. The record lacked documentation of a coccyx wound/pressure ulcer.

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F 656	Continued From page 10	F 656		

The 12/06/23 "Care Plan" lacked instructions related to the resident's coccyx wound/pressure ulcer, wound prevention, or wound treatment when the resident readmitted to the facility with the wound/pressure ulcer on 09/07/23.

The Electronic Health Records (EHR) "Physician Orders" dated 11/03/23 documented instructions to staff to apply a Mepilex dressing to the resident's coccyx and to change it one time a day, every three day(s) and as needed PRN. Staff to monitor the coccyx dressing site each shift.

The "Treatment Administration Record" (TAR) documented 11/03/23 to 12/06/23 the staff changed of the dressing to the resident's coccyx and dressing checks of the resident's coccyx dressing. This record lacked documentation of the coccyx wound/pressure ulcer care prior to 11/03/23. The wound was first documented on readmission to the facility from acute care on 09/07/23 as a coccyx slit.

The "Progress Notes" dated 09/07/23 at 04:30 PM, documented the resident re-admitted from acute care with Hospice services at 03:30 PM. Hospice in the facility to assess the resident. Skin assessment revealed an open slit to the resident's coccyx. Staff changed the Mepilex dressing to the resident's coccyx pressure ulcer. The note lacked further description or measurement of the area.

On 11/03/23 at 06:29 AM, a Skin/Wound Note documented R1 had a two centimeter (cm) open area to the coccyx. The surrounding skin was within normal limits. Staff applied a Mepilex dressing and notified the wound care nurse.

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F 656	Continued From page 11	F 656		

The EHR reviewed, revealed no further documentation with description or measurements of the wound.

Review of Hospice progress notes revealed:

On 09/07/23 documented skin as "progressing" without additional documentation found.

On 09/21/23 documented skin as "progressing".

On 10/05/23 documented skin as "progressing".

On 10/19/23 documented no skin integrity issues.

On 11/02/23 documented no skin integrity issues.

On 11/16/23 documented a one cm area of concern to coccyx.

Observations on 12/06/23 from 08:30 AM to 10:46 AM, (two hours and 16 minutes) revealed the resident sat in her recliner with feet elevated and without staff offering the resident a change of position.

On 12/06/23 at 10:46 AM Certified Nursing Assistant (CNA) G, CNA H and Licensed Nurse (LN) C entered the resident's room and assisted R7 onto the bed. The staff rolled R7 to her right side, with clothing removed and loosened the brief. The staff removed the resident's brief. LN C removed the border gauze dressing to the resident's coccyx. CNA G then performed incontinence care with R7's skin on the bottom/coccyx area appearing red in color. LN C provided the wound measurement as one cm x one half cm. She then dated/initialed the dressing after she applied it to the wound.

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Interview on 12/06/23 at 10:58 AM with CNA G revealed the staff completed every two-hour check and change of the resident for incontinence.

On 12/06/23 at 11:08 AM LN C reported she identified the resident's coccyx wound as a pressure wound that would open and close but stated that hospice was managing the wound. LN C stated she did a weekly skin assessment on all residents with wounds. LN C reported the wound was closed on 11/28/23 so no wound assessment was completed on that date. LN C reported she was not on duty when the resident readmitted from acute care and staff did not notify her of the resident's wound. The floor nurses were responsible for inputting the weekly skin assessment for residents with their showers.

On 12/07/23 at 11:30 AM Administrative Nurse F confirmed the "Comprehensive Care Plan" completed on 09/14/23 was inaccurate by not including the resident's pressure ulcer on the care plan, on 09/07/23, when returning from acute care with it.

On 12/07/23 at 12:22 PM Administrative Nurse B reported she expected the MDS, care plans and weekly skin/wound assessments to be accurate and completed.

A policy for care plans was requested on 12/07/23 with no policy provided.

The facility failed to develop a comprehensive care plan for R7 by the failure to include the residents pressure ulcer on the plan of care, on 09/07/23 when R7 returned from acute care with

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WESTERN PRAIRIE SENIOR LIVING LLC	510 E SAN JACINTO AVENUE ULYSSES, KS 67880

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it.

F 727 SS=F RN 8 Hrs/7 days/Wk, Full Time DON
CFR(s): 483.35(b)(1)-(3)

§483.35(b) Registered nurse
§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 39 residents. Based on interview and record review, the facility failed to staff the facility with a Registered Nurse (RN) for eight consecutive hours each day, as required.

Findings included:

- The facility's time sheets, schedules, and staff posting, reviewed from 07/01/22 through 06/30/2023, the last four quarters, revealed the following dates without the required eight consecutive hours of registered nurse (RN) staff:

July of 2022: 07/02-04/22, 07/09/22, 07/16-17/22, 07/23-24/22, and 07/30-31/22.

August of 2022: 08/06/22, 08/13/22, 08/20-21/22,

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and 08/27-28/22.

September of 2022: 09/03/22, 09/10-11/22, 09/18/22, and 09/24/22.

October of 2022: 10/08-09/22, 10/15-16/22, and 10/29-30/22.

November of 2022: 11/05-06/22, 11/12/22, and 11/19-20/22.

December of 2022: 12/03-04/22, 12/10-11,22, 12/17-18/22, and 12/24/22.

January of 2023: 01/01/23, 01/14/23, 01/22/23, and 01/29/23.

February of 2023: 02/04/23, 02/11/23, and 02/19/23.

March of 2023: 03/05/23, 03/19/23, and 03/26/23.

April of 2023: 04/02/23, 04/09/23, 04/15-16/23, and 04/30/23.

May of 2023: 05/07/23, 05/13/23, 05/20/23, 05/21/23,

June of 2023: 06/03/23, 06/04/23, 06/10/23, 06/11/23, and 06/18/23.

The facility lacked RN coverage for 63 days of the previous four quarters of staffing reviewed.

On 12/07/23 at 02:00 PM, Administrative Staff A, confirmed the facility lacked the required RN staffing as noted above. He reported the facility had difficulty recruiting RNs in the facility rural setting.

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F 727	Continued From page 15 The facility failed to provide a policy to address the eight consecutive hours of registered nursing staff as required. The facility failed to provide RN coverage for eight consecutive hours each day for the residents of the facility as required on 63 occasions over the previous four quarters.	F 727		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:	F 851		

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F 851	Continued From page 16 (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: The facility reported a census of 39 residents. Based on interview and record review, the facility failed to electronically submit to "Centers for Medicare and Medicaid Services, (CMS) complete and accurate direct care staffing information, including information for agency and	F 851		

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contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS {i.e., "Payroll Base Journal" (PBJ)}, related to licensed nursing staff coverage 24 hours a day and Registered Nurse (RN) coverage for eight consecutive hours each day.

Findings included:

- Review of the "Payroll Base Journal" (PBJ) Staffing Data Report for the fourth quarter of fiscal year (FY) 2022, (07/01/22 through 09/30/22), revealed the lack of a License Nurse (LN) for 24 hours/seven days a week (24/7) on 07/21/2022, 08/03/22, 08/06/22, 08/07/22, 08/09/22, 08/10/22, and 09/26/22 (seven days of the quarter).

Review of the facility's time sheets for licensed nursing staff on the above dates, revealed the facility had the required licensed nursing staff 24 hours each day, as required. The facility reported inaccurate staffing data for seven days of the above quarter.

Additionally, the "Payroll Base Journal" (PBJ) Staffing Data documented the facility lacked Registered Nurse (RN) coverage for eight consecutive hours each day on 22 dates which included 08/07/22, during the above timeframe.

Review of the facility's time sheets for licensed nursing staff on the above dates revealed the facility had the required RN coverage for 8 consecutive hours on 08/07/22. The facility reported inaccurate staffing data for seven days of the above quarter.

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Review of the "Payroll Base Journal" (PBJ) Staffing Data Report for fiscal year (FY), Quarter one of 2023, (10/01/23 through 12/31/23), revealed the lack of a License Nurse (LN) for 24 hours/seven days a week 24/7) on 10/09/22, 11/20/22, and 12/10/22.

Review of the facility's time sheets for licensed nursing staff on the above dates revealed the facility had the required licensed nursing staff 24 hours each day, as required. The facility had reported inaccurate staffing data.

Review of the "Payroll Base Journal" (PBJ) Staffing Data Report for fiscal year (FY), Quarter two of 2023 (01/01/23 through 06/30/23), documented the facility lacked RN staffing for eight consecutive hours each day on 10 dates which included 01/02/23, and 01/29/23, during the above timeframe.
Review of the facility's time sheets for licensed nursing staff on the above dates revealed the facility had the required RN coverage for 8 consecutive hours on 01/02/23 and 01/29/23. The facility submitted inaccurate staffing information.

On 12/07/23 at 02:00 PM, Administrative Staff A confirmed the facility PBJ reporting to CMS lacked accurate data to reflect direct care provided by administrative nursing staff (RN) when providing direct care. He stated the facility did have 24-hours of a LN on duty each day. The above dates on the PBJ which did not reflect LN staffing was not accurate. He also confirmed the RN coverage documentation was not accurate as noted above.

The facility lacked a policy to address the submission of accurate PBJ staffing report to

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F 851	Continued From page 19 CMS. The facility failed to electronically submit to "Centers for Medicare and Medicaid Services, (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS {i.e., "Payroll Base Journal" (PBJ)}, related to licensed nursing staff and RN coverage.	F 851		
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	F 880		

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

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

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

The facility reported a census of 39 residents with 12 residents sampled. Based on observation, interview, and record review, the facility failed to maintain an effective infection control program with the failure of staff, failed to clean a full body mechanical lift between resident uses, to change gloves and perform hand hygiene between phases of incontinence care and to perform hand hygiene between resident room contacts when delivering laundry to resident rooms. This deficient practice has the potential to lead to cross contamination between residents and negatively affect every resident in the facility.

Findings include:

- On 12/06/23 at 10:00 AM, Certified Nurse Aide (CNA) G and CNA H moved a full body mechanical lift from Resident (R)14's room out into the hallway and into R24's room. Staff failed to clean the mechanical lift after use.

On 12/06/23 at 10:08 AM, CNA G moved the mechanical lift from R24's room out into the hallway and into a supply storage closet. Staff failed to clean the mechanical lift after use.

On 12/06/23 at 10:09 AM, CNA G confirmed the mechanical lift was not cleaned between resident uses or before storage. CNA G revealed that correct procedure was to clean the mechanical lift between resident uses and before the mechanical lift was placed in storage.

On 12/07/23 at 12:09 PM, Administrative Nurse C revealed that lifts were to be cleansed/disinfected

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after every use.

The facility failed to provide a policy related to cleaning of lifts as requested on 12/07/23.

The facility failed to maintain an effective infection control program with the failure of staff to clean a mechanical lift between resident uses. This deficient practice has the potential to lead to cross contamination between residents and negatively affect every resident that required a mechanical lift in the facility.

- On 12/06/23 at 10:46 AM, R7 was in bed, and Certified Nurse Aide (CNA) G and CNA H provided incontinent
cares. Staff pulled R7's slacks down and removed the soiled disposable brief. CNA G and CNA H cleansed R7's perineum (area of the body between genitals and anus) and buttocks. CNA G and CNA H placed a clean brief on R7. Staff failed to change their gloves and perform hygiene after dirty phase of incontinence care and before clean phase of incontinence care.

On 12/06/23 at 11:06 AM, CNA G and CNA H confirmed that staff should perform hand hygiene and change their gloves between phases of incontinence cares and confirmed that they failed to perform hand hygiene and change gloves between phases of incontinence care.

On 12/06/23 at 11:08 AM, Licensed Nurse (LN) D revealed that staff were to change their gloves and should perform hand hygiene between dirty and clean phases of incontinence care.

On 12/06/23 at 11:08 AM, Administrative Nurse C

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revealed that staff where to change their gloves and perform hand hygiene between dirty and clean phases of incontinence care.

On 12/06/23 at 11:16 AM, Administrative Nurse B revealed that her expectation was for staff to change gloves and perform hand hygiene between dirty and clean phases of incontinence care.

The facility's "Hand Hygiene" policy, dated 11/28/17 documented staff were to perform hand hygiene after contact with body fluids or objects and surfaces in the resident's environment.

The facility failed to maintain an effective infection control program with the failure of staff to change gloves and perform proper hand hygiene between phases of incontinence care. This deficient practice has the potential to lead to cross contamination between residents and negatively affect every resident in the facility.

- On 12/06/23 at 02:09 PM, Laundry Staff J observed delivering laundry to multiple resident rooms without performing hand hygiene with alcohol-based hand rub (ABHR) between resident rooms.

On 12/06/23 at 02:10 PM, Laundry Staff J confirmed that she did not perform hand hygiene with ABHR between resident rooms.

On 12/07/23 at 11:24 AM, Maintenance Manager K revealed that his expectation was for laundry personnel to perform hand hygiene with ABHR between resident rooms while delivering laundry.

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F 880	Continued From page 24 On 12/07/23 at 12:09 PM, Administrative Nurse C revealed that her expectation was for staff to perform hand hygiene with ABHR between resident room contacts for any reason. Further revealed that all staff have access to individual pocket-sized containers of ABHR as provided by the facility. The facility's "Hand Hygiene" policy, dated 11/28/17 documented that staff were to perform hand hygiene with ABHR after contact with objects and surfaces in the resident's environment. The facility failed to maintain an effective infection control program with the failure of staff to perform hand hygiene between resident room contacts when delivering laundry to resident rooms. This deficient practice has the potential to lead to cross contamination between residents and negatively affect every resident in the facility.	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: The facility census totaled 39 residents. Based on observation, interview, and record review the facility failed to provide a sanitary environment by the failure to have lids on the trash cans in the soiled utility rooms. This deficient practice had the potential to be an unsanitary environment which would affect all residents in the facility.	F 921		

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Findings included:

- On 12/07/23 at 11:24 AM, Maintenance Manager K, identified three soiled utility rooms in the facility during environmental tour:

1. On the 200-hall, the trash can in the soiled utility room lacked a lid or cover.

2. On the 300-hall, the trash can in the soiled utility room lacked a lid or cover.

3. On the 400-hall, the trash can in the soiled utility room lacked a lid or cover.

On 12/07/23 at 11:30 AM, Maintenance Manager K revealed that all trash cans in the soiled utility rooms should be always covered with a lid.

On 12/07/23 at 12:22 PM, Administrative Nurse B revealed that all trash cans in the soiled utility rooms should be always covered with a lid.

On 12/07/23 at 12:30 PM, Administrative Staff A revealed that all trash cans in the soiled utility rooms should be always covered with a lid.

The facility failed to provide a policy related to lids or the covering on trash cans in the soiled utility rooms as requested on 12/07/23.

The facility failed to provide a sanitary environment by the failure to have lids or covers on the trash cans in the soiled utility rooms. This deficient practice had the potential to be an unsanitary environment which would affect all residents in the facility.