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	175471	A. BUILDING _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a health resurvey. The 2567 was sent electronically on 09/24/24.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 residents. The sample included 12 residents of which two were reviewed for pressure ulcers (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). Based on observation, record review, and interview, the facility failed to ensure pressure-reducing devices functioned correctly to prevent the worsening of pressure ulcer/injury for Resident (R) 20's coccyx (area at the base of the spine) wound. This placed the resident at risk for delayed healing or worsening of an existing	F 686		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 09/24/2024

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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pressure ulcer.

Findings included:

- The Electronic Medical Record (EMR) documented R20 had diagnoses of unspecified symptoms and signs involving cognitive functions and awareness, tremors, anorexia (lack or loss of appetite), urinary incontinence, and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).

The "Quarterly Minimum Data Set" (MDS), dated 09/07/24, documented R20 had severe cognitive impairment and rejection of care behavior for one to three days during the observation period. R20 was independent with eating and required supervision with lower body dressing, and personal hygiene. R20 was independent with rolling side to side in bed, transferring from chair to bed and bed to chair, and required supervision and touch assistance with toilet transfers. R20 had occasional incontinence of urine and frequent incontinence of bowel. The MDS further documented that R20 had occasional moderate pain which affected sleep and interfered with therapy and day-to-day activities. R20 had weight loss and received a therapeutic diet. R20 had two Stage 2 (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure ulcers/injuries. R20 had a pressure-reducing device for the chair and bed and received pressure ulcer care, application of nonsurgical dressings and ointment/medication, and nutritional/hydration interventions to manage skin issues.

R20's "Pressure Ulcer Care Area Assessment" (CAA), dated 03/07/24, documented R20 had a

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new Stage 1 (pressure wound which appears reddened, does not blanche, and may be painful but is not open) and Stage 3 (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcers. R20 spent a great deal of time in his recliner and refused position changes. The CAA further documented a new onset of urinary incontinence.

R20's "Care Plan," dated 03/12/24, documented R20 spent a great deal of time in the recliner, refused position changes, and slept through the night in his recliner at times. R20 had an air mattress on the bed and staff was directed to encourage R20 to offload pressure to his coccyx. The care plan further directed staff to identify and document potential causative factors and eliminate and resolve them when possible.

The "Physician Order", dated 09/06/24, directed staff to use wound cleanser to cleanse the wound, pat dry, and cover it every three days.

The "Wound-Weekly Observation Tool" dated 09/12/24 documented a Stage 2 coccyx wound (acquired on 04/05/24) which measured eight millimeters (mm) in length and eight (mm) in width. R20 had a ROHO cushion (pressure relief cushion that is made of soft, flexible air cells) in the wheelchair and recliner. R20 needed position changes, and dressing changes every three days and as needed, and received Prostat (a concentrated protein drink).

The "Progress Note" dated 09/17/24 documented R20 still had two small open areas on his bottom.

On 09/17/24 at 08:55 AM, observation revealed R20 sat in his recliner with his feet elevated. R20

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reported he had a sore on his bottom about the size of a pencil eraser. R20 reported staff had provided a cushion for his recliner and wheelchair. The resident verified he slept in his recliner, due to laying in bed was uncomfortable for him. R20 stated the staff had instructed him to change positions to help the pressure sore heal and said he had dressing changes to the area.

On 09/18/24 at 10:44 AM, observation revealed Licensed Nurse (LN) G provided a dressing change to R20's coccyx area. R20 had a ROHO-type cushion in the seat of the recliner that had lost air and gone flat. LN G verified the cushion went flat when pressure was applied and said that therapy had provided the cushion and LN G would contact the therapy staff to check the function of the cushion.

On 09/18/24 at 10:54 AM, Administrative Nurse D reported therapy services provided the pressure relieving cushions for R20, but the nursing staff was responsible for checking the cushion for proper inflation. Administrative Nurse D stated he would educate staff on how to ensure this was done.

The facility's "Wound Management" policy, dated 01/26/24, documented the facility is committed to providing a comprehensive wound management program to promote the resident's highest level of functioning and well-being and to minimize the development of in-house acquired pressure ulcers unless the individual's clinical condition demonstrates they are unavoidable. A commitment to the Wound Management Program is demonstrated by the implementation of processes founded on accepted standards of practice, research-driven clinical guidelines, and

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F 686	Continued From page 4 interdisciplinary involvement. Wound management principles include and are not limited to the control or elimination of causation factors such as pressure, shear, friction, moisture, and circulatory impairment. The facility failed to ensure that R20's pressure-reducing cushion functioned correctly. This placed R20 at risk for delayed healing or worsening of an existing pressure ulcer.	F 686		
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. §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,	F 756		

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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 had a census of 31 residents. The sample included 12 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported that staff failed to follow the physician's orders to administer insulin (controls the amount of sugar in the blood by moving into cells) and medications to treat Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). This placed the resident at risk for physical decline and an ineffective medication regimen.

Findings included:

- The Electronic Medical Record (EMR) for R2 documented diagnoses of Parkinson's disease, diabetes mellitus type two (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension

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F 756	Continued From page 6	F 756		

(high blood pressure), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Quarterly Minimum Data Set" (MDS), dated 05/02/24, documented R2 had intact cognition. R2 required setup assistance with eating, dressing, and personal hygiene, and was independent with toileting, mobility, and transfers. The assessment revealed R2 received insulin during the observation period.

The "Annual MDS," dated 08/01/24, documented R2 had moderately impaired cognition. R2 required setup assistance with eating, dressing, and personal hygiene, and was independent with toileting, mobility, and transfers. The assessment revealed R2 received insulin.

R2's "Care Plan," dated 8/05/24 and initiated on 01/16/21, directed staff to administer medications as ordered and to monitor and document side effects and effectiveness. The update, dated 03/18/22, directed staff to obtain Accu-checks (blood glucose monitoring test), administer insulin per the physician's order, and update the physician per request related to blood glucose readings.

The "Physician's Order," dated 11/25/19, directed staff to administer Sinemet (medication used to treat Parkinson's disease), 25-100 milligrams (mg). two tablets, by mouth, every eight hours, for Parkinson's disease.

R2's "Medication Administration Record" dated

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July 2024 lacked documentation that staff administered the Sinemet medication on the following days:
07/11/24 at 06:00 AM
07/23/24 at 06:00 AM

R2's "Medication Administration Record" dated August 2024 lacked documentation that staff administered the Sinemet medication on the following days:
08/04/24 at 06:00 AM

R2's "Medication Administration Record" dated September 2024 lacked documentation that staff administered the Sinemet medication on the following days:
09/02/24 at 10:00 PM

The "Physician's Order," dated 05/13/24, directed staff to administer Novolog (a fast-acting insulin), 15 units, subcutaneous (under the skin), three times per day, for diabetes mellitus type two.

R2's "Treatment Administration Record" dated July 2024 lacked documentation the insulin was administered on the following days:
07/10/24 in the evening
07/29/24 in the evening

The "Physician's Order," dated 07/22/24, directed staff to administer insulin glargine (a long-acting insulin), 35 units, subcutaneous, twice per day, for diabetes mellitus type two.

R2's "Treatment Administration Record" dated August 2024 lacked documentation the insulin was administered on the following days:
08/17/24 at 07:00 PM
08/21/24 at 07:00 PM.

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R2's "Treatment Administration Record" dated September 2024 lacked documentation the insulin was administered on the following days: 09/14/24 at 07:00 PM.

The "Medication Regimen Review" for the months of July, August, and September 2024 lacked evidence the CP identified and reported R2 had not been administered the ordered medication and insulin.

On 09/17/24 at 12:25 PM, observation revealed Licensed Nurse (LN) G washed her hands, obtained gloves, wiped R2's finger with alcohol, obtained his blood sugar, and told him he did not need his insulin.

On 09/18/24 at 11:13 AM, Administrative Nurse D stated he had not been made aware by the CP that R2 had not received the as-ordered medication and insulin.

The facility's "Consultant Pharmacist Services Provider Requirements" policy, dated 09/18/24, documented that the consultant pharmacist provided pharmaceutical care services and reviewed the medication regimen of each elder in the health center at least monthly incorporating federally mandated standards of care in addition to other applicable professional standards, and documenting the review and finding in the elder's clinical record. The CP communicates potential or actual problems related to medication therapy orders to the responsible physician and the Director of Nursing and reviews medication administration records, physician orders, and administration of the medications to the elders. The CP also monitors to ensure the appropriate

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F 756	Continued From page 9 review is documented in the elder's clinical record. The facility failed to ensure the CP identified and reported that staff failed to follow the physician's orders to administer insulin and medications to treat Parkinson's disease. This placed the resident at risk for physical decline and an ineffective medication regimen.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 residents. The sample included 12 residents, with six reviewed	F 757		

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F 757	Continued From page 10	F 757		

for unnecessary medications. Based on observations, record review, and interview, the facility failed to administer medication as ordered by the physician for one resident, Resident (R) 2, who received insulin (controls the amount of sugar in the blood by moving into the cells) and medications to treat Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). This placed the resident at risk for unnecessary medication side effects and an ineffective medication regimen.

Findings included:

- The Electronic Medical Record (EMR) for R2 documented diagnoses of Parkinson's disease, diabetes mellitus type two (when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), delusional disorder (untrue persistent belief or perception held by a person although evidence shows it was untrue), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

The "Quarterly Minimum Data Set" (MDS), dated 05/02/24, documented R2 had intact cognition. R2 required setup assistance with eating, dressing, and personal hygiene, and was independent with toileting, mobility, and transfers. The assessment revealed R2 received insulin during the observation period.

The "Annual MDS," dated 08/01/24, documented

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R2 had moderately impaired cognition. R2 required setup assistance with eating, dressing, and personal hygiene, and was independent with toileting, mobility, and transfers. The assessment revealed R2 received insulin.

R2's "Care Plan," dated 8/05/24 and initiated on 01/16/21, directed staff to administer medications as ordered and to monitor and document side effects and effectiveness. The update, dated 03/18/22, directed staff to obtain Accu-checks (blood glucose monitoring test), administer insulin per the physician's order, and update the physician per request related to blood glucose readings.

The "Physician's Order," dated 11/25/19, directed staff to administer Sinemet (medication used to treat Parkinson's disease), 25-100 milligrams (mg), two tablets, by mouth, every eight hours, for Parkinson's disease.

R2's "Medication Administration Record" dated July 2024 lacked documentation that staff administered the Sinemet medication on the following days:
07/11/24 at 06:00 AM
07/23/24 at 06:00 AM

R2's "Medication Administration Record" dated August 2024 lacked documentation that staff administered the Sinemet medication on the following days:
08/04/24 at 06:00 AM

R2's "Medication Administration Record" dated September 2024 lacked documentation that staff administered the Sinemet medication on the following days:

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F 757	Continued From page 12 09/02/24 at 10:00 PM The "Physician's Order," dated 05/13/24, directed staff to administer Novolog (a fast-acting insulin), 15 units, subcutaneous (under the skin), three times per day, for diabetes mellitus type two. R2's "Treatment Administration Record" dated July 2024 lacked documentation the insulin was administered on the following days: 07/10/24 in the evening 07/29/24 in the evening The "Physician's Order," dated 07/22/24, directed staff to administer insulin glargine (a long-acting insulin), 35 units, subcutaneous, twice per day, for diabetes mellitus type two. R2's "Treatment Administration Record" dated August 2024 lacked documentation the insulin was administered on the following days: 08/17/24 at 07:00 PM 08/21/24 at 07:00 PM. R2's "Treatment Administration Record" dated September 2024 lacked documentation the insulin was administered on the following days: 09/14/24 at 07:00 PM. On 09/17/24 at 12:25 PM, observation revealed Licensed Nurse (LN) G washed her hands, obtained gloves, wiped R2's finger with alcohol, obtained his blood sugar, and told him he did not need his insulin. On 09/17/24 at 03:19 PM, LN G stated R2 required three different insulins and stated that after the insulin was administered, it was documented in the medical record.	F 757		

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F 757	Continued From page 13 On 09/18/24 at 11:13 AM, Administrative Nurse D stated if R2 had not received his insulin, staff were to document in the medical record the reason why it was not administered. The facility's "Administering Medications Using Electronic Medication Administration Record" policy, dated 09/16/24, documented the facility administered medications in a safe manner and completed accurate and timely "real-time" documentation of all medication administration using the Electronic Medical Record (eMAR) system utilized in the facility. All medications would be administered to every resident as ordered by a physician in a safe and sanitary manner. If the resident or representative refused medication or the resident was unable to take medication as scheduled, click the appropriate box on the eMar as "not done" and provide a documented explanation. The facility failed to administer medications as ordered by the physician for R2, who received insulin and Parkinson's disease medication. This placed the resident at risk for unnecessary medication side effects and an ineffective medication regimen.	F 757		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population	F 801		

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F 801	Continued From page 14 in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a	F 801		

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person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents and one kitchen. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to employ a full-time Certified Dietary Manager for the 31 residents who reside in the facility and received their meals

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F 801	Continued From page 16 from the kitchen. This placed the residents at risk of not receiving adequate nutrition. Findings included: - On 09/16/24 at 08:10 AM, observation revealed the kitchen staff finishing the morning meal and preparing the midday meal. Dietary Staff CC stated the Dietary Manager had the day off and planned on returning within the survey period. On 09/18/24 at 08:30 AM, Dietary Staff BB reported he is in the process of obtaining a certified dietary manager course. The facility's "Organizational Plan and Roles of Key Staff" policy, dated 2020, documented in states without an established minimum standard, the following qualifications of the Dining Service Manager should be considered: Certified Dietary Manager credential. The facility failed to employ a full-time Certified Dietary Manager for 31 residents who reside in the facility, which placed the residents at risk of inadequate nutrition.	F 801		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) 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	F 851		

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F 851	Continued From page 17 CMS. §483.70(p)(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(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (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(p)(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.	F 851		

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F 851	Continued From page 18 §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(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 had a census of 31 residents. Based on observation, interview, and record review the facility failed to submit complete and accurate staffing information through Payroll Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Service (CMS) for Fiscal Year (YR) 2023 Quarter (Q) 4, FY 2024 Q1, Q2, and Q3 indicated the facility did not have licensed nurse coverage 24 hours a day, seven days a week on multiple days. (FY 2023 Quarter 4: 11 dates and FY 2024 Quarter 1: 5 days, Quarter 2:25 days and Quarter 3: 5 days). A review of the facility's licensed nurse data or the dates listed on the PBJ revealed a licensed nurse on duty 24 hours a day seven days a week. On 09/18/24 at 10:00 AM, observation revealed a licensed nurse on duty in the facility. On 09/18/24 at 11:51 AM Administrative Staff A	F 851		

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F 851	Continued From page 19 reported the facility sent the payroll information to a corporate office and it was submitted to the PBJ from there. She stated there was a nurse on duty at all times, and the information submitted was not accurate. The facility's "Mandatory Submission of Uniform Format Staffing Information (PBJ-Payroll Based Journal) policy, dated 09/18/24, documented the facility will electronically submit to the Centers for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contracted staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by Centers for Medicare and Medicaid Services. The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.	F 851		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		

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F 880	Continued From page 20 §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 §483.71 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	F 880		

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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 31 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) were used for Resident (R) 20 who had an ongoing pressure ulcer and dressing change. The deficient practice placed the resident at risk of infectious disease processes.

Findings included:

- On 09/17/24 at 08:55 AM, observation revealed R20's door had an EBP sign and supply tote with personal protective equipment (PPE) of gloves, gowns, and eye protection shields next to the door. R20 sat in his recliner with his feet elevated. R20 reported he had a sore on his bottom about the size of a pencil eraser. R20 said he had dressing changes to the area.

On 09/18/24 at 10:44 AM, observation revealed Licensed Nurse (LN) G provided a dressing

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change to R20's coccyx area. LN G washed her hands, placed disposable gloves on, and proceeded to assist R20 into the bathroom. LN G removed the dressing from R20's coccyx area and cleansed it with wound cleanser. LN G reported she had forgotten to bring a dressing for the wound and left the room. Upon returning to the room, LN G placed gloves on and dressed the wound. LN G had not donned a gown while assisting R20 in the bathroom or during the dressing change.

On 09/18/24 at 10:48 AM LN G verified she had not worn a gown and should have during R20's care and dressing change.

On 09/18/24 at 10:54 AM, Administrative Nurse D verified LN G should have worn a gown during R20's care and dressing change.

The facility's "Enhanced Barrier Precautions (EBP) policy, dated 05/04/24, documented the facility follows recommendations and guidance from the Centers for Disease Control in order to keep all residents safe from Healthcare Acquired Infections (HAI). On the recommendation and approval of the facility's Infection Preventionist in collaboration with the facility's Medical Director, Enhanced Barrier Precautions are implemented as one intervention this facility uses to reduce transmission of resistant organisms that employ targeted PPE use during high-contact resident care activities.

The facility failed to ensure staff used EBP while caring for R20, who had an ongoing pressure ulcer and dressing change. The deficient practice placed the resident at risk for facility-acquired infections.

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F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: The facility had a census of 31 residents. The sample included 12 residents. Based on interviews and record review, the facility failed to ensure the staff person designated as the Infection Preventionist (IP) who was responsible for the facility's Infection Prevention and Control Program (IPCP) completed the specialized training in infection prevention and control. This placed the 31 residents in the facility at risk for lack of identification and treatment of infections. Findings included: - On 09/17/24 at 01:15 PM, Administrative Nurse E stated she was responsible for the IPCP and was in the process of taking the class. Administrative Nurse E confirmed she was not	F 882		

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F 882	Continued From page 24 certified. The facility's "Infection Control Policy," dated 03/13/23 documented the IP was responsible for overseeing the Infection Control program and was required to have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related fields, and be qualified by education, training, experience, or certification. The policy documented that the IP was required to work at least part-time at the facility, have completed specialized infection prevention and control training, and participate in the Quality Assurance Performance Improvement (QAA) committee regularly. The facility failed to ensure the staff person designated as the IP possessed the required certification, placing the residents at increased risk for infections.	F 882		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 883		

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has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 31 residents. The sample included 12 residents, with five reviewed for immunizations to include pneumococcal (a disease that refers to a range of illnesses that affect various parts of the body and are caused by infection) vaccinations. Based on record review and interview, the facility failed to follow the latest guidance from the Centers for Disease Control and Prevention (CDC) when they failed to offer and administer or obtain an informed declination, or a physician-documented contraindication for Resident (R)3, R6, R20, R21, and R22, pneumococcal PCV20 vaccination. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease.

Findings included:

- Review of R3, R6, R20, R21, and R22's clinical medical records lacked evidence the facility or the resident representative received or signed consent or informed declination for the current pneumococcal vaccine PCV20. The records lacked evidence of a physician-documented contraindication.

On 09/17/24 at 01:15 PM, Administrative Nurse E stated the facility only offered the PVC20 to new residents but did not have documentation that it was ever offered and declined.

The facility's "Flu/Pneumonia Vaccine" policy, dated 01/31/24, documented influenza and pneumonia vaccines would be administered by appropriately qualified personnel who are following facility procedures, without the need for

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WESTY COMMUNITY CARE HOME	105 N HIGHWAY 99 WESTMORELAND, KS 66549

(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 883	Continued From page 27 an individual physician evaluation or order other than the signed standing orders. Each person offered the vaccine(s) would be provided with current information from the CDC and Federal Drug Administration regarding the benefits and risks of the vaccine. Every year, a log documenting how many people (residents, staff, and volunteers) receive influenza and Pneumovax vaccine, as well as the number who refused and did not receive the vaccination. The resident's clinical record would document that the resident and/or surrogate decision-maker was provided education regarding the benefits and potential side effects of the vaccines. The documentation would include whether the resident received the vaccines or refused to receive the immunizations due to medical contraindications or refusal. The facility failed to offer the pneumococcal PCV20 vaccinations per CDC recommendations. This deficient practice placed the residents at risk of acquiring, spreading, and experiencing complications from pneumococcal disease.	F 883		