| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The following citations represent the findings of a Health Resurvey.<br><br>The 2567 was sent electronically on 10/30/24. | F 000 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. | F 582 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/30/2024

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 582 | Continued From page 1<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>The facility had a census of 22 residents. The sample included 12 residents. Based on record review and interview, the facility failed to provide Resident (R)16, R22, and R74, or their representatives, the completed Centers for Medicare and Medicaid (CMS) "Skilled Nursing Facility Advanced Beneficiary Notices" (ABN) Form 10055. This placed the resident at risk of uninformed decisions about their skilled services.<br><br>Findings included:<br><br>- The "Medicare ABN form 10055" informed the beneficiary that Medicare may not pay for future skilled therapy services. The form included an option for the beneficiary to receive specific | F 582 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 582 | Continued From page 2 | F 582 | | |

services listed, and bill Medicare for an official decision on payment. The form stated 1) "I understand if Medicare does not pay, I will be responsible for payment but can make an appeal to Medicare," (2) "receive therapy listed, but do not bill Medicare, I am responsible for payment for services," (3) "I do not want the listed services."

A review of the ABN provided to R16 revealed form CMS-R-131 was issued instead of CMS Form 10055. The resident's skilled services ended on 08/16/24 and R16 remained in the facility.

A review of the ABN provided to R22 revealed form CMS-R-131 was issued instead of CMS Form 10055. The resident's skilled services ended on 08/23/24 and R22 remained in the facility.

A review of the ABN provided to R74 revealed form CMS -R-131 was issued instead of CMS Form 10055. The resident's skilled services ended on 04/24/24 and R74 remained in the facility.

On 10/23/24 at 08:30 AM, Administrative Staff A verified the facility provided the CMS-R-131 form to R16, R22, or R74 instead of the ABN CMS-10055.

The facility's "Advance Beneficiary Notices" policy, dated February 2024, recorded the facility would inform residents in advance when changes would occur to their bill. The facility issues the Skilled Nursing Advanced Beneficiary Notice (CMS form 10055). The resident (or representative) is informed that they may choose

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 582 | Continued From page 3<br>to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility.<br><br>The facility failed to provide R16, R22, and R74 or their representatives, the correct ABN CMS-10055 form which included an estimated cost of continued services when discharged from skilled care and remaining in the facility. This placed the residents at risk of uninformed decisions about their services and the continuation of their skilled services. | F 582 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. | F 657 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 657 | Continued From page 4 | F 657 | | |

(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 22 residents. The sample included 12 residents with four residents reviewed for urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag.) Based on observation, interview, and record review the facility failed to revise the care plan for Resident (R) 16 who was on 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). This deficient practice placed R16 at risk for impaired care due to uncommunicated care needs.

Findings included:

- R16's Electronic Medical Record (EMR) documented diagnoses of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections,) hypertension (HTN-elevated blood pressure,) and dementia (a progressive mental disorder characterized by failing memory and confusion.

The "Quarterly Change Minimum Data Set (MDS)," dated 09/17/24, documented the resident had severely impaired cognition. The MDS documented R16 was dependent on staff for all activities of daily living (ADLs). The MDS documented R16 had an indwelling catheter.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 657 | Continued From page 5 | F 657 | | |

R16's "Care Plan," dated 07/07/24, directed staff to monitor, record and report to the physician any signs and symptoms of urinary tract infection, pain, burning, blood-tinged urine, cloudiness, lack of urine output, increased pulse, and increased temperature. The care plan directed the staff to notify the physician if the resident had foul-smelling urine, fever, chill, altered mental status, behavior change, and change in eating patterns. The care plan documented the staff would perform good catheter and peri care at the end of every shift and report any redness or concerns to the charge nurse. The care plan lacked any direction for the staff regarding the EBP care and precautions.

On 10/23/24 at 12:10 PM observation revealed Certified Nurse Aide (CNA) M entered the room of R16, who had a Foley catheter. CNA M assisted R16 in ambulating with a walker from his recliner to the bathroom toilet. Observation in the bathroom revealed a plastic tote with personal protection equipment (PPE-supplies including gown and gloves). Continued observation revealed CNA M donned gloves but no gown, disconnected the drain spout from its sleeve at the bottom of the drainage bag, opened the valve on the drain spout, drained the urine into a plastic graduated cylinder (a plastic container with a volume scale used for measuring liquids), cleaned the spout with an alcohol wipe, closed the spout then reattached to the drainage spout to the bag. CNA M assisted the resident with personal care and the resident ambulated with the walker back to his recliner.

On 10/23/24 at 04:00 PM interview with Administrative Nurse D verified the care plan lacked documentation the resident required EBP

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 657 | Continued From page 6<br>and staff care of the resident with EBP.<br><br>The facility's "Care Plan-Goals and Objectives" policy, dated April 2024, stated the facility would incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plan goals and objectives are defined as the desired outcomes for a specific resident population. Care plan goals and objectives are entered into the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. Goals and objectives are reviewed and/or revised when there has been a significant change in the resident's condition when the desired outcome has not been achieved, when the resident has been readmitted to the facility from the hospital/rehabilitation stay, and at least quarterly. The resident has the right to refuse to participate in establishing care plan goals and objectives. When such refusals are made, appropriate documentation will be entered into the resident's clinical record in accordance with established policies.<br><br>The facility failed to revise R16's "Care Plan" to include EBP. This placed R16 at risk for impaired care due to uncommunicated care needs. | F 657 | | |
| F 726 SS=F | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial | F 726 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 726 | Continued From page 7 | F 726 | | |

well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 22 residents. The sample included 12 residents. Based on record review and interview, the facility failed to ensure one nurse aide had the appropriate skills, competencies, and active certification and failed to ensure Licensed Nurse staff had the knowledge and skills to safely pass medications to the residents. This placed the residents at risk for impaired quality of care.

Findings included:

- On 10/23/24 at 02:00 PM, a review of Certified

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 726 | Continued From page 8 | F 726 | | |

Nurse Aide (CNA) N certification on the Registry Certification and Credentialing site revealed CNA N had an Aide ID issued on 12/18/19 and her certification was marked inactive on 12/18/21. CNA N had been employed at the facility since 07/12/22.

On 10/24/24 at 08:30 AM, Administrative Nurse D verified, after reviewing the State of Kansas Nurse Aide Registry Certification and Credentialing database, that CNA N had an inactive certification. Administrative Nurse D verified she would contact the state's credentialing office to get guidance on how to get CNA N's certification renewed so she could work at the facility.

The "Nurse Aide Qualifications and Training Requirements," policy, dated August 2024, documented Nurse Aides must undergo a state-approved training program. "Nurse Aide" is any individual providing nursing or nursing-related services to residents in the facility. The term may include an individual who provides these services through an agency or under a contract with the facility but is not a licensed health professional, a registered dietician, or someone who volunteers to provide such service without pay. The facility will only employ those nurse aides who meet the requirements set forth in the federal and state statutes concerning the staffing long long-term care facilities. The facility will not employ any individual as a nurse aide for more than 4 months full-time, temporary. Per diem, or otherwise, unless the individual is competent to provide designated nursing care and nursing-related services; and that individual has completed a training program and competency evaluation program, or a competency evaluation program

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 726 | Continued From page 9 | F 726 | | |

approved by the state, or the individual has been deemed competent as provided in the requirements of participation.

The facility failed to ensure one nurse aide had the active certification, placing the residents who resided in the facility at risk of receiving impaired quality of care.

- On 10/24/24 at 09:52 AM, observation revealed Licensed Nurse (LN) G stood at the counter in the nurse workroom. There were five residents' medication cups, four with residents' initials, two without writing, with assorted pills in each cup on the counter. LN G verified she had set the medications up that morning in the locked cabinets in the residents' rooms. LN G said when she saw the residents were back from an activity, she brought the medication cups to the nurse workroom. LN G stated she had not put the initials on the two cups because she knew who the medications belonged to. LN G said she probably should not have set the medications up beforehand. Further observation revealed the nurse's workroom lacked a door. LN G left the nurse's room to administer another resident's medication, with the medication cups still on the counter unattended.

On 10/24/24 at 10:00 AM, Administrative Nurse E stated she expected staff to go to the resident's cabinet at the time a resident's medication was supposed to be administered and pop the pills into the medication cup at that time. Administrative Nurse E stated that depending on which resident it was, the nurse should watch the resident take the pills.

The facility's "Administering Oral Medications

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 726 | Continued From page 10<br>Policy," revised October 2023, documented that staff should follow the procedure when administering residents' oral medications:<br>1. Wash hands.<br>2. Arrange supplies in the medication cabinet.<br>3. Place the Medication Administration Record (MAR) within easy viewing distance.<br>4. Unlock the medication cabinet.<br>5. Select the drug from the cabinet.<br>6. Check the label on the medication and confirm the medication name and dose with the MAR.<br>7. Check the expiration date on the medication. Return any expired medications to the pharmacy.<br>8. Check the medication dose. Re-check to confirm the proper dose.<br>9. For unit dose tablets or capsules. Place packaged medications directly into the medication cup.<br><br>The facility failed to provide a licensed nurse with adequate competency and skills to safely administer medications for the 22 residents residing in the facility. This placed the residents who resided at the facility at risk for medication errors. | F 726 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program. | F 880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 11 | F 880 | | |

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 §483.71 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 | | |

(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 22 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to adhere to infection control for Enhanced Barrier Precautions (EBP -an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and gloves used during high contact resident care activities), for Resident (R)16, who had an urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag.) This placed the resident at risk for infection.

Findings included:

- On 10/23/24 at 12:10 PM observation revealed Certified Nurse Aide (CNA) M entered the room of R16, who had a urinary catheter. CNA M assisted R16 in ambulating with a walker from his recliner to the bathroom toilet. Observation in the bathroom revealed a plastic tote with personal

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 | | |

protection equipment (PPE-supplies including gown and gloves). Continued observation revealed CNA M donned gloves but no gown, disconnected the drain spout from its sleeve at the bottom of the drainage bag, opened the valve on the drain spout, drained the urine into a plastic graduated cylinder (a plastic container with a volume scale used for measuring liquids) cleaned the spout with an alcohol wipe closed the spout then reattached to the drainage spout to the bag. CNA M assisted the resident with personal care and the resident ambulated with the walker back to his recliner.

On 10/23/24 at 04:00 PM interview with Administrative Nurse D and Administrative Staff A verified the staff should wear PPE for EBP when providing care for R16. They verified they had the PPE equipment in the resident's bathroom but had not informed the staff of the need for its use. Administrivia Staff A stated they would go and do some education with the staff in regard to the EBP and wearing PPE for the resident's care. Administrative Staff A said she would post the necessary signage in the resident's bathroom regarding the use of PPE for a resident on EBP.

The facility's "Enhanced Barrier Precautions in Skilled Nursing Communities" policy, dated January 2024, documented the facility would fully implement EBP as an infection prevention and control intervention to reduce the spread of multi-resistant organisms (MDROS) to residents. EBP's employ targeted gowns and gloves during high-contact resident care activities when contact precautions do not otherwise apply. Gloves and gowns are applied prior to performing the high-contact resident care activity (as opposed to before entering the room). PPE is changed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175565 | A. BUILDING _____ B. WING _____ | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUNPORCH OF SMITH COUNTY | 920 E KANSAS AVE SMITH CENTER, KS 66967 |

| (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 | | |

before caring for another resident. Face protection may be used if there is a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBP's include dressings, device care or use (central line, urinary catheter, feeding tubes, tracheostomy/ventilator,) a wound care (any skin opening requiring a dressing.) EBP's are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBP's remain in place for the duration of the resident's stay or until resolution with wounds or discontinuation of the indwelling medical device that puts them at increased risk. The use of the EBPs does not impose limitations on group activities or room restrictions for residents. Staff are trained in caring for the residents on EBPs. Signs are posted inside the door or wall directly inside the resident's room indicating the type of precautions and PPE required. PPE is available directly inside the resident's room. Residents, families, and visitors are notified of the implementation of EBPs throughout the facility.

The facility failed to adhere to infection control standards and policies for R16, who required EBP, which placed the resident at risk for possible exposure to illness.