

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Winfield Rest Haven II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1611 Ritchie Winfield, KS 67156	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560</p> <p>The facility reported a census of 40 residents with 14 residents selected for review. Based on observation, interview, and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS), assessment for two of the 14 residents. Residents (R)35 had an inaccurate assessment regarding impairment in extremities, and R12 had an inaccurate assessment regarding the use of positioning bars as a restraint.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)12's medical record revealed diagnoses that included dementia (progressive mental disorder characterized by failing memory, confusion), osteoarthritis(degenerative changes to one or many joints characterized by swelling and pain), and ataxia (impaired ability to coordinate movement). <p>The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. The resident used two bed rails daily and was marked as a restraint.</p> <p>The Physical Restraint Care Area assessment dated [DATE], assessed the resident used quarter rails on the bed to promote independence/participation with bed mobility, and documented the side rails did not prevent him from getting in and out of bed.</p> <p>The Care Plan dated 11/11/24, instructed staff the resident utilized the quarter rails to promote independence/participation with bed mobility and they did not prevent him from getting in and out of the bed.</p> <p>The Siderail Use assessment dated [DATE], documented the resident currently used the side rail for positioning or support.</p> <p>During an observation on 12/03/24 at 07:53 AM, the resident grabbed the positioning rail on the right side of the bed and pulled himself over with staff assistance.</p> <p>During an interview on 12/03/24 at 08:00 AM, CNA Q revealed the resident used the positioning bar for assisting staff to turn him in bed. CNA Q said the resident was able to grab the bar on the right and left side of the bed to turn. CNA Q said the resident did not try to get out of bed himself and the rail was not big enough to keep him in bed.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/03/24 at 02:49 PM, CNA O revealed the resident used the positioning rail to assist with turning himself from side to side. CNA O stated the resident did not try to get out of bed.</p> <p>During an interview on 12/04/24 at 11:30 AM, Administrative Staff A confirmed the side rail (positioning rail) was not used as a restraint and the MDS was incorrectly coded.</p> <p>The facility utilized the RAI (Resident Assessment Instrument) manual for MDS completion.</p> <p>The facility failed to ensure R12's use of the positioning rail was accurately coded as not a restraint on the MDS.</p> <p>- Review of Resident (R)35's medical record revealed diagnoses that included hemiplegia (paralysis of one side of the body) on the right dominant side, cerebral vascular accident (CVA/stroke, sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), seizure disorder (violent involuntary series of contractions of a group of muscles), agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and expressive aphasia (condition with disordered or absent language function).</p> <p>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS indicated the resident had no impairments in his upper or lower extremities.</p> <p>The ADL [Activity of Daily Living] Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 01/25/24, documented the resident had functional limitations and weakness to his right upper and lower extremity and used a wheelchair. The resident required substantial assistance with transfers and bathing.</p> <p>The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of five. The resident had one sided impairment of the upper extremity and was dependent on staff for transfers and bathing.</p> <p>The Care Plan, dated 01/22/24, instructed staff the resident was dependent of two staff for bathing/showering twice a week and as needed. The resident required use of a mechanical lift for transfers.</p> <p>During an observation on 12/03/24 at 08:13 AM, Certified Nurse Aide (CNA) NN and CNA Q, provided morning care to the resident. The resident could not voluntarily move his right arm and exhibited weakness in his right leg. CNA NN and CNA Q transferred the resident with a mechanical lift from his bed into his wheelchair. CNA Q stated the resident was not able to stand to transfer.</p> <p>During an interview on 12/03/24 at 02:30PM, CNA O revealed staff provided extensive assistance for ADLs and utilized the mechanical lift to transfer the resident since he could not stand.</p> <p>Interview, on 12/04/24 at 11:30 AM, with Administrative Staff A, revealed the resident could not actively move his right arm and used his left hand to feed himself. The resident had weakness in his right leg and could not stand or walk so staff utilized the mechanical lift for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview, on 12/04/24 at 12:00 PM, with Consulting Staff GG, revealed she completed the MDS with use of staff assessments of the resident and did not physically see the resident to confirm the accuracy of the compilation of staff assessments. Consulting Staff GG confirmed the Admission MDS dated [DATE] assessed the resident with no limitations in his upper and lower extremities, but the ADL Functional/Rehabilitation Potential CAA indicated the resident had functional limitations and weakness to his right upper and lower extremities which made the MDS inaccurate.</p> <p>The facility utilized the RAI (Resident Assessment Instrument) manual for MDS completion.</p> <p>The facility failed to accurately assess R35's impairment in his upper extremity as required.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36881</p> <p>The facility reported a census of 40 residents. The sample of 14 residents included two residents reviewed for enhanced barrier precautions. Based on observation, interview, and record review the facility failed to review and/or revise care plans for two residents, Resident (R) 26 and R30 to include enhanced barrier precautions related to residents with catheters and nephrostomy tubes.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R) 26's Physician Orders, (PO) dated 11/21/24, included diagnoses of transient ischemic attack (TIA- TIA- temporary episode of inadequate blood supply to the brain), cerebral infarction (CVA/stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), morbid obesity (severely overweight), and incontinence with catheter use associated with terminal illness. <p>The Significant Change in Status Minimum Data Set, (MDS), dated [DATE], documented the resident with the Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. She had frequent incontinence of urine with an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid).</p> <p>The Quarterly MDS dated [DATE], documented the resident had a BIMS score of 14, which indicated no cognitive impairment. The resident required a urinary catheter.</p> <p>The Urinary Incontinence and Indwelling Care Area Assessment, (CAA), dated 07/29/24, documentation included the resident admitted to hospice services on 07/26/24 with diagnose of congestive heart failure, incontinent of bowel and bladder with indwelling catheter, had episode of extreme confusion with behaviors. She required staff assistance with her activities of daily living (ADLS).</p> <p>The Care Plan, dated 11/18/24, directed staff to know R26 had an indwelling foley Catheter related to incontinence of bladder and a terminal condition. The Care Plan lacked instruction to staff regarding the required use enhanced barrier precautions (EBP) and associated personal protective equipment (PPE) during the provision of care for a resident with an indwelling catheter to prevent cross contamination and the spread of infection.</p> <p>The Physician Order dated 11/21/24, included an 08/15/24 order for a 16 French (catheter size), foley catheter.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/03/24 at 10:12 AM, R26's door had an Enhanced Barrier Precaution (EBP) sign that directed staff in the use of required personal protective equipment (PPE-which included gowns), for the provision of direct care for residents with catheters. A container with (PPE) was located outside of the resident's room entrance. Administrative Nurse E entered R 26's room without applying the required isolation gown. Upon entering the room Certified Nurse Aide (CNA) P was present in the room bathing the resident. During the observation CNA P also handled the resident's catheter and initiated the removal of her catheter collection bag without the use of an isolation gown. Administrative Nurse E further assisted CNA P with bathing the resident, peri-care, and catheter care without the application of an isolation gown to prevent cross contamination and the spread of infection.</p> <p>On 12/03/24 at 10:25 AM CNA P identified the resident as requiring an indwelling catheter. She stated staff should follow the required application of PPE when providing direct care to residents with catheters. Appropriate enhanced barrier precautions included gowns when providing direct care to residents to prevent cross contamination and the spread of infection. She confirmed R 26's catheter leaked, and she should have applied an isolation gown prior to providing care to the resident to prevent cross contamination and the spread of infection.</p> <p>On 12/03/24 at 01:26 PM, Administrative Nurse E, confirmed the above findings. She stated the care plan provided the staff with guidance regarding the individual needs of the residents. Administrative Nurse E stated she and CNA P should have worn an isolation gown during R26's catheter care and personal hygiene to prevent cross contamination and the spread of infection.</p> <p>The facility policy Care Plans, Comprehensive Person-Centered dated 03/2022, documented a comprehensive person-centered care plan to meet the resident's physical, psychosocial and functional needs for each resident to include the right to receive services in keeping with person-centered care.</p> <p>The facility failed to review and/or revise care plans for (R)26 related to enhanced barrier precautions associated PPE provided for residents with catheters.</p> <p>28560</p> <p>- Review of Resident (R)30's medical record revealed diagnoses that included renal failure (inability of the kidneys to excrete wastes, concentrate urine and conserve electrolytes) with dependence on dialysis (a procedure that removes excess fluid and waste from the blood when the kidneys are no longer functioning properly) and hydronephrosis (a condition that occurs when urine builds up in the kidneys causing them to swell and stretch).</p> <p>The Significant Change Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderate cognitive impairment.</p> <p>The ADL [Activity of Daily Living] Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 05/07/24, assessed the resident with chronic kidney disease and received hemodialysis and had hydronephrosis, which necessitated suprapubic (a tube placed through the skin and into the bladder to drain urine from the bladder) and nephrostomy catheters (tubes that enter the kidneys from incisions through the skin to drain the build up of urine).</p> <p>The Care Plan reviewed 10/31/24, instructed staff the resident had a suprapubic catheter and bilateral nephrostomy catheters. The care plan lacked instruction for EBP (Enhanced Barrier Precautions).</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation, on 12/03/24 at 01:25 PM, revealed Certified Nurse Aide (CNA) Q, donned gloves, and a gown to empty the resident's suprapubic catheter and bilateral nephrostomy catheters. The resident's room door contained signage that the resident was on EBP with PPE (personal Protective Equipment) in a cabinet in the room.</p> <p>During an interview on 12/04/24 at 10:30 AM, Administrative Nurse D confirmed the resident was on EBP due to the presence of the suprapubic catheter and nephrostomy tubes.</p> <p>During an interview on 12/04/24 at 12:00 PM, Consulting Staff GG revealed the facility staff should indicate on the care plan if the resident was on EBP.</p> <p>The facility policy Care Plans, Comprehensive Person Centered revised March 2022, instructed staff to revise the care plan as information about the resident and resident condition changes.</p> <p>The facility failed to review and revise R30's care plan to include EBP as required.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560</p> <p>The facility reported a census of 40 residents with 14 residents selected for review which included three residents reviewed for accidents. Based on observation, interview, and record review the facility failed to ensure staff secured one Resident (R)35 in the whirlpool bath chair which resulted in a fall from the chair onto the floor and R35 obtained a forehead laceration that required eight sutures in the emergency room .</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)35's medical record revealed diagnoses that included hemiplegia (paralysis of one side of the body) on the right dominant side, cerebral vascular accident (CVA/stroke, sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), seizure disorder (violent involuntary series of contractions of a group of muscles), agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and expressive aphasia (condition with disordered or absent language function). <p>The Admission Minimum Data Set (MDS), dated [DATE], assessed the resident with a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS indicated the resident had no impairments in his upper or lower extremities.</p> <p>The ADL [Activity of Daily Living] Functional/Rehabilitation Potential Care Area Assessment (CAA), dated 01/25/24, documented the resident had functional limitations and weakness to his right upper and lower extremity and used a wheelchair. The resident required substantial assistance with transfers and bathing.</p> <p>The Quarterly MDS dated [DATE], assessed the resident with a BIMS score of five. The resident had one sided impairment of the upper extremity and was dependent on staff for transfers and bathing.</p> <p>The Care Plan, revised 08/01/24, instructed staff the resident was dependent of two staff for bathing/showering twice a week and as needed.</p> <p>The Care Plan revised 09/20/24, instructed staff the resident was dependent on one to two staff for bathing/showering twice a week and as needed. Staff instructed to place a safety belt on the resident if a bath was taken.</p> <p>The Fall Risk Evaluation dated 07/16/24, assessed the resident with decreased muscular coordination, intermittent confusion, and a total score of 13 (greater than 10 indicated a high risks for potential falls).</p> <p>Review of R35's medical record Fall Note revealed on 09/19/24 at 08:49 PM, the resident fell from the whirlpool bath chair when the CNA transferred the resident out of the whirlpool, without the safety belt on. The resident hit his head on the floor and sustained a laceration above his right eye and transported to the emergency room for evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the emergency room report, dated 09/19/24, revealed the laceration above the right eyebrow, required eight sutures.</p> <p>During an observation on 12/03/24 at 08:13 AM, Certified Nurse Aide (CNA) NN and CNA Q, provided morning care to the resident. The resident could not voluntarily move his right arm and exhibited weakness in his right leg. CNA NN and CNA Q transferred the resident with a mechanical lift from his bed into his wheelchair. CNA Q stated the resident was not able to stand to transfer.</p> <p>During an interview on 12/03/24 at 02:30PM, CNA O revealed staff provided extensive assistance for ADLs and utilized the mechanical lift to transfer the resident since he could not stand.</p> <p>During an interview on 12/03/24 at 03:28 PM, CNA MM revealed on 09/19/24 at approximately 08:00 PM, she provided a whirlpool bath to R352. CNA MM stated she did not apply the whirlpool bath chair safety belt to the resident and stood beside the resident as she transferred him out of the bathtub. CNA MM said while R35 was seated in the chair, he leaned forward and fell on to the floor, and sustained a laceration to his forehead. CNA MM stated prior to the R35's fall, she did not consistently use the safety belt on the whirlpool bath chair. CNA MM stated now the facility required all residents to wear the safety belt when taking a bath.</p> <p>During an interview on 12/03/24 at 03:40 PM, Administrative Nurse D revealed she expected staff to apply the safety belt on residents when utilizing the whirlpool bath chair, to keep residents safe.</p> <p>During an interview on 12/04/24 at 10:00 AM, Administrative Staff A stated the use of the safety belt was required for all residents who utilized the whirlpool bath chair, except for two residents who have refused to allow staff to apply the belt (R 35 was not one of the two who refused). Administrative Staff A stated she expected staff to ensure the resident was safe in the chair during the bath and when moving the resident in and out of the whirlpool to keep a hand on the resident. Administrative Staff A stated she provided instruction on safe bathing practice for staff to include holding firmly onto the resident when transferring in and out of the whirlpool and use of the safety belt for all residents.</p> <p>The facility policy Bath, Shower/Tub dated February 2018, instructed staff to assist the resident out of the tub or shower and hold firmly to the resident and move slowly. The policy lacked additional safety instructions.</p> <p>The facility failed to ensure staff used the safety belt for R35 during transfer out of the whirlpool bath, which resulted in a fall with a laceration and required eight sutures.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34056</p> <p>The facility reported a census of 40 residents with 14 residents sampled including five residents reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to monitor one Resident (R)35 for use of antipsychotic medications (drugs used to treat psychosis-related conditions and symptoms).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of Resident (R)35's electronic medical record (EMR) revealed a diagnosis of anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear). <p>The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. He received antipsychotic medication (drugs used to treat psychosis-related conditions and symptoms) on a routine basis during the assessment period.</p> <p>The Psychotropic Drug Care Area Assessment (CAA), dated 10/02/24, documented the resident had right side weakness due to a history of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of artery to the brain) and anxiety.</p> <p>The Quarterly MDS, dated [DATE], lacked assessment of the resident's cognitive status. He received antipsychotic medication on a routine basis during the assessment period.</p> <p>The Care Plan, revised 10/11/24, instructed staff the resident received antipsychotic medication and staff were to monitor the resident for possible side effects of the medication.</p> <p>Review of the resident's EMR revealed the following Physician Orders:</p> <p>Seroquel (an antipsychotic medication), 25 milligrams (mg), by mouth (PO), at hour of sleep (HS), for restlessness and agitation (characteristics of anxiety), ordered 06/20/24. The physician discontinued (DC'd) this order on 08/24/24.</p> <p>Seroquel, 50 mg, PO, every day for anxiety, ordered 06/20/24. The physician discontinued this order on 08/24/24.</p> <p>Seroquel 25 mg, PO, at HS, related to restlessness and agitation, ordered 08/24/24.</p> <p>Review of the resident's EMR revealed an Abnormal Involuntary Movement Scale (AIMS) assessment (a clinical outcome scale used to assess abnormal movements in people who take antipsychotic medications), dated 10/09/24, which indicated the resident had no involuntary movements. No other AIMS assessments were documented in the resident's EMR.</p> <p>(continued on next page)</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's Medication Administration Record (MAR) from 06/20/24 through 12/03/24, revealed the resident received all scheduled doses of his medication.</p> <p>On 12/04/24 at 11:03 AM, Administrative Staff A stated the facility had not complete an AIMS assessment on the resident when the physician first ordered the antipsychotic medication in June, as they should have. The facility did complete the AIMS assessment in October. Administrative Staff A confirmed there were no other AIMS assessments completed for the resident and said the facility expected staff to complete the assessment at least every 90 days.</p> <p>The facility policy, Antipsychotic Medication Use, revised July 2022, included: An AIMS assessment will be completed upon the initiation of antipsychotic medications and then quarterly thereafter.</p> <p>The facility failed to complete the AIMS assessments for monitoring of adverse reactions for R35 who received antipsychotic medication.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28560</p> <p>The facility reported a census of 40 residents. Based on observation, interview and record review, the facility failed to ensure staff donned appropriate PPE (personal Protective Equipment) for three of five residents on enhanced barrier precautions (EBP, an intervention to reduce the transmission of infections during high contact care activities) to prevent the spread of infection. Residents (R)23, R29 and R26.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Observation on 12/03/24 at 10:30 AM, revealed Licensed Nurse (LN) G provided Resident (R)29 PEG tube percutaneous enteral gastric tube (a feeding tube that passes through the skin and enter into the stomach to administer nutrition, fluids, medication) dressing change and administration of water. LN G donned gloves but did not don a gown to change the dressing or administer water through the PEG tube. The resident's room lacked signage for staff awareness of the need for PPE (Personal Protective Equipment) for Enhanced Barrier Precautions an intervention to reduce the transmission of infections during high contact care activities. Observation on 12/03/24 at 02:00 PM, revealed LN G provided wound care to R23. LN G donned gloves but did not don a gown. LN G leaned across the resident's bed and her clothing came in contact with the resident's bedding to access the resident's right heel. LN G stated the resident had a chronic wound to his right foot, but it was not open at this time and did not think EBP were necessary. During an interview on 12/04/24 at 11:59 AM, Administrative Nurse D confirmed R29 was on EBP for her PEG tube and R23 for his right heel wound (who had MRSA in the wound culture 02/20/24). Administrative Nurse D stated she expected staff to follow the EBP guidelines when providing high contact resident care. <p>The facility policy Enhanced Barrier Precautions revised March 2024 instructed staff to don gloves and a gown prior to performing high contact resident care activity.</p> <p>The facility failed to ensure staff utilized EBP for the provision of high contact resident care for R29 and R23 to prevent the spread of infection to the residents of the facility.</p> <p>36881</p> <ul style="list-style-type: none"> - Review of Resident (R)26's Physician Orders, (PO) dated 11/21/24, included diagnoses of transient ischemic attack (TIA- TIA- temporary episode of inadequate blood supply to the brain), cerebral infarction (CVA/stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), morbid obesity (severely overweight), and incontinence with catheter use associated with terminal illness. <p>The Significant Change in Status Minimum Data Set, (MDS), dated [DATE], documented the resident with the Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. She had frequent incontinence of urine with an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175488	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2024
NAME OF PROVIDER OR SUPPLIER Winfield Rest Haven II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1611 Ritchie Winfield, KS 67156	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Quarterly MDS dated [DATE], documented the resident had a BIMS score of 14, which indicated no cognitive impairment. The resident required a urinary catheter.</p> <p>The Urinary Incontinence and Indwelling Catheter Care Area Assessment, (CAA), dated 07/29/24, included the resident admitted to hospice services on 07/26/24 with a diagnosis of congestive heart failure, incontinence of bowel and bladder with indwelling catheter, and episodes of extreme confusion with behaviors. She required staff assistance with her activities of daily living (ADLS).</p> <p>The Care Plan, dated 11/18/24, directed staff to know R26 had an indwelling foley Catheter related to incontinence of bladder and a terminal condition. The Care Plan lacked instruction to staff regarding the required use of enhanced barrier precautions (EBP) and associated personal protective equipment (PPE) during the provision of care for a resident with an indwelling catheter to prevent cross contamination and the spread of infection.</p> <p>The Physician Order dated 11/21/24, included an 08/15/24 order for a 16 French (catheter size), foley catheter.</p> <p>On 12/03/24 at 10:12 AM, R26's door had an Enhanced Barrier Precaution (EBP) sign that directed staff in the use of required personal protective equipment (PPE-which included gowns), for the provision of direct care for residents with catheters. A container with (PPE) was located outside of the resident's room entrance. Administrative Nurse E entered R 26's room without applying the required isolation gown. Upon entering the room Certified Nurse Aide (CNA) P was present in the room bathing the resident. During the observation CNA P also handled the resident's catheter and initiated the removal of her catheter collection bag without the use of an isolation gown. Administrative Nurse E further assisted CNA P with bathing the resident, peri-care, and catheter care without the application of an isolation gown to prevent cross contamination and the spread of infection.</p> <p>On 12/03/24 at 10:25 AM CNA P identified the resident as requiring an indwelling catheter. She stated staff should follow the required application of PPE when providing direct care to residents with catheters. Appropriate enhanced barrier precautions included gowns when providing direct care to residents to prevent cross contamination and the spread of infection. She confirmed R 26's catheter leaked and she should have applied an isolation gown prior to providing care to the resident to prevent cross contamination and the spread of infection.</p> <p>On 12/03/24 at 01:26 PM, Administrative Nurse E, confirmed the above findings and stated the resident's catheter bag leaked urine and the resident was wet so she requested help from CNA P to change the resident and replace her catheter bag. Administrative Nurse E confirmed she failed to apply the required PPE when administering direct care to R26 with an indwelling catheter. Administrative Nurse E stated she and CNA P should have worn an isolation gown during R 26's catheter care to prevent cross contamination and the spread of infection.</p> <p>The facility policy Enhanced Barrier Precautions, dated 03/2024, included enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms to residents. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resistant care activities when contact precautions do not otherwise apply. High-contact resident care activities requiring the use of gowns include bathing, dressing, toileting, transferring, and device care or use of catheters.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Winfield Rest Haven II, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1611 Ritchie Winfield, KS 67156	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility failed to provide safe and sanitary care with the use of EBP to prevent cross contamination and the spread of infection for R26.</p>