

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E071	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Greeley County Hospital Ltcu		STREET ADDRESS, CITY, STATE, ZIP CODE 506 3rd Street Tribune, KS 67879	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768</p> <p>The facility had a census of 16 residents. The sample included nine residents with two reviewed for skin issues. Based on observation, interview, and record review the facility failed to perform weekly skin assessments and follow-up documentation of non-pressure related skin issues found for Resident (R) 9, placing R9 at risk for further skin issues.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R9's Electronic Medical Record (EMR) documented diagnoses of dermatitis (swelling and irritation of the skin), history of venous thrombosis (a clot that developed within a blood vessel) absence of the right leg above the knee, and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS documented that R9 was independent with eating and required staff assistance with dressing toileting and mobility. The MDS documented R9 was at risk for pressure ulcers (localized injury to the skin or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) but had no skin issues.</p> <p>R9's Care Plan, dated 11/02/23 and revised on 04/24/24, stated the resident required skin inspection (weekly and as needed) and directed staff to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse.</p> <p>The Progress Note, dated 07/01/24 documented an open wound approximately one centimeter (cm) by 0.5cm, on R9's lower left leg just below the knee. The note stated the site had been oozing clear fluid and the nurse covered it with a 2x2 gauze and band-aid.</p> <p>R9's EMR had no follow-up note or assessment of the skin issue and the next skin assessment was dated 07/26/24, three and half weeks later.</p> <p>The Skin Assessment, dated 07/26/24, documented a scabbed area to the top of R9's left second toe, measuring 1 cm x 0.5 cm, and a band-aid was applied.</p> <p>R9's EMR had no follow-up note or assessment of the skin issue and the next skin assessment was dated 08/13/24, over two weeks later.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 17E071
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the documented Skin Assessments revealed four separate weeks without an assessment (07/07-13/24, 07/14-20/24, 07/28/24 - 08/03/24, 08/04-10/24.)</p> <p>On 08/29/24 at 08:59 AM, observation revealed R9 was in bed. Administrative Nurse D performed a skin check and found no skin issues on R9's left leg and toe.</p> <p>On 08/27/24 at 08:05 AM, Administrative Nurse D verified staff had not documented skin assessments weekly and she verified staff should have followed up on the documented skin issues of 07/01/24 and 07/26/24.</p> <p>The facility's Skin Assessment policy, dated 08/29/24, stated all residents would receive a head-to-toe skin assessment on admission and weekly thereafter. Any skin issues identified should be documented on the assessment form.</p> <p>The facility failed to perform weekly skin assessments and follow-up documentation of skin issues found for R9. This placed R9 at risk for further skin issues due to the lack of routine skin assessments and follow-up of identified skin issues.</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** 27168</p> <p>The facility had a census of 16 residents. The sample included nine residents with two reviewed for accidents. Based on observation, record review, and interview the facility failed to ensure an environment free from accidents for Resident (R)3, when staff served her a hot beverage in the wrong cup. R3 spilled the hot beverage on her abdomen, which caused a second-degree burn (potentially painful burn that affects the first and second layer of the skin) and placed the resident at risk for increased pain.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R3's Electronic Health Record (EHR) revealed diagnoses of multiple sclerosis (MS-a disorder of the central nervous system marked by weakness, numbness, a loss of muscle coordination, and problems with vision, speech, and bladder control), major depressive disorder (major mood disorder which causes persistent feelings of sadness), dysphagia (swallowing difficulty), and weakness. <p>R3's Admission Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview Mental Status (BIMS) score of 13, indicating intact cognition. The assessment revealed the resident required set-up assistance with eating.</p> <p>R3's Hot Liquid assessment dated [DATE], documented a score of three and a score of two that indicated a risk of spills from hot liquid. The assessment documented the resident was to have hot liquids in a cup with lids.</p> <p>R3's Care Plan, dated 06/27/24, recorded R3 required staff assistance with most activities of daily living (ADL) care. The care plan documented the resident had a self-care performance deficit with contractures (abnormal fixation of a joint or muscle) and could feed herself. The plan documented that staff would assist with cutting up her food. The plan directed staff to serve hot liquids in a lidded cup, due to R3's documented risk of spills from hot liquids.</p> <p>R3's Care Conference dated 07/10/24, documented the resident had honey-thickened liquids, preferred water only, and used a Kennedy cup (a lightweight, easy to grip, no-spill cup that only dispensed liquids as the resident sucked on the straw) with meals.</p> <p>R3's EHR recorded a Progress Note, dated 07/25/24 at 09:14 AM, that documented R3 dropped her Styrofoam cup of hot cocoa, and the lid came off; this caused the cocoa to spill onto R3's abdomen. Staff called the clinic, and no new orders were obtained at that time. Staff made an appointment for R3 to see the physician in the morning.</p> <p>The Progress Note, dated 07/25/24 at 11:26 AM, documented R3 went to the hospital to see the physician. R3's abdomen was assessed and had redness that remained on the upper abdomen under the breast area. The area was 0.6 centimeters (cm) with round, raised, fluid-filled blisters in the middle of the burned area. The physician ordered medication for the burned area.</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>The late entry Progress Note, dated 07/25/24 at 11:40 AM, documented R3 had a hot liquid spill incident. The staff were educated, and a report was sent to the state agency. The note documented the burn occurred because the resident was in isolation for positive COVID-19 (highly contagious respiratory virus) status and dietary staff served her meals and liquids in disposable containers. R3's hot liquids were served in a Styrofoam cup. The note recorded that dietary staff were operating under old COVID-19 guidelines where disposable plates and cups were used.</p> <p>The Progress Note, dated 07/26/24 at 11:01 AM, documented R3 continued to have burns to the top of her abdomen under the breast. The area was red with one blister present, approximately 1 cm, round, and fluid-filled. Staff applied bacitracin (a topical antibiotic ointment) and Telfa (non-stick dressing) dressing.</p> <p>The Progress Note, dated 07/27/24 at 12:09 AM, documented R3 had a dressing in place on the abdomen on the burns. R3's skin continued to be blistered. The resident denied discomfort.</p> <p>The Progress Note, dated 07/27/24 at 09:55 AM, documented that staff applied bacitracin ointment topically one time a day for blisters to R3's abdomen and covered with a nonadherent gauze dressing until healed. The note documented the resident's skin continued with redness to the right upper abdomen under her breast with one large fluid-filled clear blister to the inner upper abdomen. When the dressing change was completed, R3 complained the area was tender to touch.</p> <p>The Physician Notes, dated 07/30/24 at 03:43 PM documented R3's provider visited to follow up on the burn to R3's abdomen but issued no new orders.</p> <p>R3's Skin assessment dated [DATE], documented a faded area with slight redness to the upper mid-abdomen. The area was small, scaly, and had a scab healing. The assessment noted no open areas.</p> <p>R3's Hot Liquid Assessment, dated 08/08/24 (14 days after the hot liquid burn), documented the resident had a neurological diagnosis, a psychiatric diagnosis, poor muscular control, and low mobility. The assessment documented the resident had experienced burns from a previous spill and would benefit from a burn-proof protector during the consumption of hot liquids. The assessment documented the resident could not manage hot liquids independently and was at risk for hot liquid spills.</p> <p>On 08/28/24 at 07:50 AM, observation revealed R3 sat in a wheelchair at the dining room table dressed in street clothes. Continued observation revealed the resident had three drinks in Kennedy cups.</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>On 08/27/24 at 09:30 AM, Administrative Nurse D verified she was on vacation when the incident occurred. Administrative Nurse D stated the resident was diagnosed with COVID-19 on 07/15/24 and was in her room on isolation precautions. Administrative Nurse D verified the dietary staff prepared a room tray for the resident that included a Styrofoam cup with a lid and a straw but due to the resident's limited mobility, hand contractures, and weakness, she put a hole in the cup when she grabbed it and the lid popped off resulting in the liquid leaking on her abdomen. This caused burns. Administrative Nurse D verified the resident was supposed to have a Kennedy cup, not a Styrofoam cup, and that is the reason she sustained the burns to her abdomen. Administrative Nurse D instructed the dietary department it was ok for an isolation resident to have the Kennedy cups instead of the Styrofoam and they could sanitize the cup. Administrative Nurse D verified the facility completed a hot liquid assessment upon admission on 06/27/24. Administrative Nurse D stated that after R3's burn incident, the facility utilized a new Hot Liquid Assessment that used more information to identify residents at risk for burns and spills.</p> <p>The facility's Hot Beverage policy dated 08/14/24 , documented that all hot beverages served to residents in their room or dining room would be in insulated mugs and the temperature should not exceed 160 degrees Fahrenheit.</p> <p>The facility failed to provide R3 with the correct Kennedy cup to prevent hot liquid accidents resulting in R3 spilling the hot liquid on her abdomen which caused a second-degree burn and placed the resident at risk for increased pain.</p> <p>The facility completed all corrective actions, to include staff education, by 08/15/24, prior to the onsite survey. Therefore, the deficient practice was deemed past noncompliance at a G scope and severity.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26768</p> <p>The facility had a census of 16 residents. The sample included nine residents. Based on observation, interview, and record review the facility failed to label and date one vial of insulin (a hormone that lowers the level of glucose in the blood) for Resident (R) 15, placing R15 at risk of receiving expired or ineffective insulin.</p> <p>Findings included:</p> <p>- On [DATE] at 09:24 AM, observation in the facility's medication storage room revealed one Fiasp (fast-acting insulin) insulin vial which had been accessed, but not dated at that time.</p> <p>On [DATE] Medlineplus.Gov documented unrefrigerated unopened vials, cartridges, and pens of insulin aspart solution (Fiasp) can be used within 28 days, but after that time they must be discarded.</p> <p>On [DATE] at 09:24 AM, Administrative Nurse D verified the vial should have been dated when opened and first accessed.</p> <p>The facility's Medication Labeling and Storage policy, dated [DATE], stated medications would be labeled and stored in accordance with facility requirements and state and federal laws. Multi-dose vials that have been opened or accessed would be dated and discarded within 28 days unless the manufacturer specified a different date for that vial.</p> <p>The facility failed to date R15's vial of insulin when opened, placing her at risk of receiving ineffective insulin.</p>

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<p>F 0851</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.</p> <p>27168</p> <p>The facility had a census of 16 residents. Based on record review and interview, 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.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024 Quarter 1 indicated no licensed nurse coverage on the following dates: <p>10/08/23, 10/09/23, 10/15/23, 10/22/23, 10/28/23, 11/05/23, 11/11/23, 11/16/23, 11/23/23, 11/24/23, 12/03/23, 12/17/23, and 12/30/23.</p> <p>A review of the facility's licensed nurse payroll data for the dates listed above revealed a licensed nurse was on duty 24 hours a day, seven days a week.</p> <p>On 08/27/24 at 11:30 AM, Administrative Nurse D verified the facility had submitted nursing hours and data for the PBJ that lacked the coverage of the agency and hospital RN coverage. Administrative Nurse D verified the nurse clock in hours and the facility had nurse coverage on all the days documented above.</p> <p>The Mandatory Submission of Uniformed Staffing Information, dated 08/29/24 documented the facility complete submission of staffing information-based payroll data in a uniform format as specified by regulatory requirements. The facility would electronically submit to the Centers for Medicare and Medicaid Services (CMS). The data would include the category of work for each person on direct care staff, including, but not limited to if the individual is a registered nurse (RN)), licensed practical nurse (LPN), certified nursing assistant, therapist, or other type of medical personnel as specified by CMS. The Director of Nursing (DON) would review that monthly to ensure accurate reporting and notify the designated person assigned to data submission as to any corrections needing to be made. Prior to the end of the quarter submissions, the DON would again review entire quarterly submissions to ensure accurate reporting and notify the designated person assigned data submission as to any corrections needing to be made.</p> <p>The facility failed to submit accurate PBJ data which placed the residents at risk for unidentified and ongoing inadequate staffing.</p>		