STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175488	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winfield Rest Haven II, LLC	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings included: - 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). 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. 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. The Quarterly MDS dated 07/29/24, 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. 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. 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. 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 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	potential falls). 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. Review of the Emergency Room report, dated 09/19/24, revealed the laceration above the right eyebrow, required eight sutures. 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. 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. 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 onto 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. 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. 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. 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. 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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. Findings included: - 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. 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. 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. - 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. 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). The Quarterly MDS dated 10/09/24, documented the resident had a BIMS score of 14, which indicated no cognitive impairment. The resident required a urinary catheter. The Urinary Incontinence and Indwelling Catheter Care Area Assessment, (CAA), dated 07/29/24, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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). 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. The Physician Order dated 11/21/24, included an 08/15/24 order for a 16 French (catheter size), foley catheter. 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. 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. 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. 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. 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.