

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2023
NAME OF PROVIDER OR SUPPLIER Medicalodges Great Bend		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Cherry Lane Great Bend, KS 67530	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Provide and implement an infection prevention and control program.</p> <p>42966</p> <p>The facility identified a census of 44 residents. Based on observations, record review, and interviews, the facility failed to ensure oxygen tubing was stored properly, failed to ensure adequate hand hygiene, failed to prevent cross-contamination with sit-to-stand (mechanical lift that helps patient rise from a seated to a standing position) lift usage, failed to prevent cross-contamination with glucometer (device used to obtain a blood sugar level), and failed to ensure proper usage of personal protective equipment (PPE- gowns, face shields and/or eye glasses/goggles, and gloves). This deficient practice had the risk to spread illness and infection to all residents.</p> <p>Findings included:</p> <p>- On 08/30/23 at 09:52 AM, Resident (R) 1's oxygen tubing was coiled up and laid on her concentrator, not stored in a bag.</p> <p>On 08/30/23 at 09:58 AM, Certified Nurse Aide (CNA) M wore gloves and transported a red biohazard bag to the soiled utility room. She exited the soiled utility room within seconds, no longer wearing gloves. CNA M pushed a sit-to-stand lift into the clean storage room, exited within seconds, then proceeded down the hallway. Hand hygiene was not performed during this observation.</p> <p>On 08/30/23 at 10:02 AM, Certified Medication Aide (CMA) R prepared medications at the medication cart then entered R2's room and administered her medications using a spoon. She exited R2's room, went back to the medication cart, and pushed it down the hallway. Hand hygiene was not performed after administering R2's medications.</p> <p>On 08/30/23 at 10:06 AM, R3 was in droplet precautions (safeguards designed to reduce the risk of droplet transmission of infectious agents, spread primarily through coughing, sneezing and talking) for COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) CNA M wore a KN-95 (higher level respirator mask) mask, donned (put on) gloves then an isolation gown. She entered R3's room without donning eye protection as required with droplet precautions.</p> <p>On 08/30/23 at 11:14 AM, CNA M and CNA N entered R5's room with the sit-to-stand lift.</p> <p>On 08/30/23 at 11:19 AM, CNA N exited R5's room with the sit-to-stand lift and a soiled trash bag, she pushed the sit-to-stand lift into the clean utility room without disinfecting the lift after usage.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/30/23 at 11:31 AM, Licensed Nurse (LN) G entered R6's room with a tray that contained a glucometer and glucometer supplies (lancets, alcohol pads, and glucometer strips). He donned gloves then cleansed the glucometer strip port on the glucometer but did not clean the entire device. LN G obtained R6's blood sugar then cleansed the glucometer strip port after use without disinfecting the entire device. He placed the glucometer back in the tray on top of the glucometer supplies, doffed (removed) gloves, and placed the tray on top of the nurses' cart. He did not perform hand hygiene after doffing gloves and before proceeding down the hallway with the glucometer tray to R7's room.</p> <p>On 08/30/23 at 11:35 AM, LN G entered R7's room with glucometer tray and donned gloves. He cleansed the glucometer strip port only then placed the glucometer on the bedside table without a barrier. He obtained R7's blood sugar then placed the glucometer in the tray on top of the supplies and doffed gloves without performing hand hygiene afterward. LN G exited R7's room with glucometer tray, placed on top of the nurses' cart, then into the top drawer. He did not disinfect the glucometer device after use.</p> <p>On 08/30/23 at 12:22 PM, R4 was on droplet precautions for COVID-19. CMA R wore a KN-95, donned an isolation gown and gloves then entered R4's room to administer medications. She did not wear eye protection into R4's room as required with droplet precautions.</p> <p>On 08/30/23 at 12:28 PM, CNA O wore a KN-95 mask, donned an isolation gown, placed a surgical mask over her KN-95 and entered R4's room with his lunch. She did not wear eye protection into R4's room as required with droplet precautions.</p> <p>On 08/30/23 at 01:06 PM, R1's oxygen tubing was coiled up and laid on top of her oxygen concentrator, not stored in a bag.</p> <p>On 08/30/23 at 11:38 AM, LN G stated he was told when disinfecting the glucometer device before and after use, there was a four-minute wet time required for disinfection, but he was curious what the required wet time was now.</p> <p>On 08/30/23 at 01:40 PM, CNA N stated hand hygiene was performed when entering and upon exiting rooms and after doffing gloves. She stated cross-contamination was prevented by disinfecting the mechanical lifts after use and the sanitizing wipes were kept in the clean utility room. CNA N stated she knew if a resident was on isolation by the computer charting and there was a sign on the door that said to ask the nurse before entering the room. She stated she talked to the nurse to find out what type of isolation the resident was on and what PPE was required. CNA N stated the PPE required for COVID-19 was isolation gown, mask, face shield, and gloves. The proper sequence for donning PPE for COVID-19 isolation was gown, gloves, face shield, and mask. She stated oxygen tubing was stored properly in a bag.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/30/23 at 01:46 PM, LN H stated hand hygiene was performed before entering and after exiting resident rooms and after doffing gloves. She stated cross-contamination was prevented by wiping the mechanical lifts with sanitizing wipes between each person. LN H stated cross-contamination was prevented with glucometer usage by cleansing the entire device before and after use and a barrier was used during the procedure. She stated she knew what residents were on isolation because staff discussed what residents were on isolation and a sign was on their door that stated to stop and see the nurse. LN H stated the PPE required for COVID-19 precautions was a gown, N-95 mask, gloves, and depending on how bad the infection was, a face shield. She stated the proper sequence for donning PPE was gloves, isolation gown, surgical mask over the N-95 she already wore, and face shield before going into the room. LN H stated oxygen tubing was stored in a bag when not in use.</p> <p>On 08/30/23 at 01:56 PM, Administrative Nurse D stated hand hygiene was performed anytime going into and coming out of a resident's room and before and after using gloves. She stated cross-contamination was prevented with mechanical lift usage by cleaning in between each use. Glucometers were cleansed before and after each use and when obtaining a blood sugar, the glucometer was cleaned before placed back in the glucometer tray. She stated she placed the glucometer in the tray during the procedure and she did not place it on the bedside table. Administrative Nurse D stated a resident's isolation status was located in their electronic medical record (EMR), there was a sign on their door, and an isolation cart outside their room. She stated the resident's main page listed what isolation they were on and what PPE staff were to wear. Administrative Nurse D stated the PPE required for COVID-19 precautions included isolation gown, gloves, N-95, and eye protection and the sequence for donning PPE was N95, gloves, gown, and eye protection. She stated oxygen tubing was stored in a bag when not in use.</p> <p>The facility's Infection Management Process policy, last revised October 2022, directed employees had available proper PPE to use during work time which included gloves, gowns, masks, and eye shields and employees were educated with orientation and at least yearly on proper hand hygiene to include hand washing and hand hygiene. The policy directed the Center for Disease Control (CDC) guidelines were the resource for the implementation of appropriate isolation procedures. Glucometers were properly sanitized between each use and staff were educated on appropriate drying time before using.</p> <p>The facility's Checklist for Controlling COVID-19 in Long-Term Care Facility policy, last revised 05/15/23, directed gloves, gowns, face masks, and eye protection were used when providing care to residents in droplet precautions.</p> <p>The facility failed to ensure oxygen tubing was stored properly, failed to ensure adequate hand hygiene, failed to prevent cross-contamination with sit-to-stand lift usage, failed to prevent cross-contamination with glucometer, and failed to ensure proper usage of PPE. This deficient practice had the risk to spread illness and infection to all residents.</p>		