### Summary Statement of Deficiencies

An Initial Certification Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Centers for Medicare & Medicaid Services (CMS). The facility was found not to be in substantial compliance with the Conditions of Participation (CoP) for Acute Care Hospitals at 42 CFR part 482.12, Governing Body, 482.21, Quality Assurance and Performance Improvement, 482.26, Radiologic Services, 482.28, Food and Nutrition Services, and 482.42, Infection Control.

**Survey Dates:** 5/8/17 through 5/12/17

**Survey Census:** 46 in-center patients

**Sample Size:** 31

**Supplemental Sample:** None

#### A 043 Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...

This CONDITION is not met as evidenced by:

- Based on observation, interview, and review of facility records, by-laws, policies, and procedures, the facility failed to meet the Condition of Participation (CoP) for Governing Body.
- Specifically:
  1. The Governing Body failed to ensure the Food

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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.
A. BUILDING  
______________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  
H061002  

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING _____________________________  
B. WING _____________________________  

(X3) DATE SURVEY COMPLETED  
05/12/2017  

NAME OF PROVIDER OR SUPPLIER  
ADAIR ACUTE CARE AT OSAWATOMIE STATE HOSPITAL  

STREET ADDRESS, CITY, STATE, ZIP CODE  
500 STATE HOSPITAL DRIVE  
OSAWATOMIE, KS 66064  

(X5) COMPLETION DATE

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  

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Service Director (FSD) adequately managed the daily operations of the food service department and failed to ensure the food service staff received the necessary education and specialized training to ensure competence in their respective duties. Refer to findings A 0622.

2. The Governing Body failed to ensure their Quality Assurance and Performance Improvement (QAPI) Committee had an ongoing program measuring improvements and outcomes for identified concerns related to the facility's dietary services. The QAPI Committee did not analyze and track indicators relative to the Food Service Department. Consequently, the QAPI Committee did not develop plans of actions with measurable goals and timetables to ensure any identified concerns would not continue in the future. Refer to findings at A 0283.

3. The Governing Body failed to ensure that diagnostic radiological services were provided onsite or available through a contractual agreement with an off-site facility. Refer to findings at A 0528.

4. A). The Governing Body failed to ensure the food service contractor maintained a sanitary environment for food storage and preparation to prevent the transmission or outbreak of a foodborne illness.

B). The Governing Body failed to ensure that identified adverse events related to infection control were investigated and brought to the QAPI Committee for development of performance improvement activities. Refer to findings at A 0749.
The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the QAPI committee met to discuss identified concerns within several departments throughout the facility. They failed to address concerns relative to the Food and Dietetics Department, the Infection Control program, and Utilization Review. This deficient practice had the potential to affect all of the patients who received services through this facility.

Findings include:

1. Review of the facility's policy and procedure titled, "Quality Assessment Performance Improvement Program," dated 7/29/16, provided the following information in part:
ADRA ACUTE CARE AT OSAWATOMIE STATE HOSPITAL

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<th>A 263</th>
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<td>Policy -</td>
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This hospital's quality assessment and performance improvement (QAPI) program will:

- Reflect the complexity of the hospital's programs and services.
- Involve all hospital departments and services (including those furnished under contract or arrangement).
- Focus on indicators related to improved health outcomes as well as the prevention and reduction of medical errors.

This is done through developing, implementing, and maintaining an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program ...

Data Collection and Analysis

All hospital departments and services (including those furnished under contract or arrangement) will be involved in the hospital's QAPI program ...

For those services provided through contractual agreements, the Department Head or designee responsible for oversight for the services of the contract will work with the contractor to develop QAPI measures and identify opportunities for improvement."

During an interview on 5/9/17 at 1:30 p.m., the QAPI/Risk Manager and the Chief Medical Officer (CMO) confirmed that the facility's QAPI team and the Committee of the Whole (COW) did not oversee the contracted Food Service...
### A263 Continued From page 4

Department. When interviewed about how the facility could identify concerns in the main kitchen and in the small kitchens on Units 1 and 2 if they did not oversee the departments, the QAPI/Risk Manager and the CMO stated they could not.

During an interview on 5/11/17 at 9:00 a.m., the Food Service Director (FSD) and the District Manager stated the contracted Food Service Department did not have a Quality Assurance and Performance Improvement (QAPI) plan or committee and they did not bring identified concerns to the facility's administration. The FSD and the District Manager stated they did not attend the facility's QAPI meetings and they did not have a QAPI committee of their own. When asked how they identified concerns throughout the kitchen and developed a plan of action with measurable goals with time tables to ensure that the identified concerns would not continue in the future, the FSD and the District Manager stated they were unsure. Refer to findings at A 0283.

2. Review of the facility's Infection Control Reports, and the facility's Quality Assurance and Performance Improvement (QAPI) program plan, the facility failed to develop action plans for infection control issues identified by the surveillance process for 3 patients (Patient (P) 24, P 25, and P 26) of 30 patients reviewed for documented healthcare associated infections (HAIs). Refer to findings at A 0283.

3. Review of the facility's policy and procedure titled, "Utilization Review Plan," dated 9/6/16, provided the following information:

Policy: The Utilization Review Plan provides for review of admissions to (Name of the facility) for
SUMMARY STATEMENT OF DEFICIENCIES

A 263 Continued From page 5
medical necessity. This includes review of
duration of stay and professional series furnished
to patients ...

Procedure: The Utilization Review Committee is
responsible for implementing, monitoring, and
evaluating the effectiveness of the Utilization
Review Plan ...

Review of the reports titled, "Diagnostic
Threshold/Outlier Days for December, January
and February Admissions" dated 12/16/16
through 3/20/17, indicated that each month the
facility had patients whose medical record
required a comprehensive review by the
Utilization Review (UR) Committee due to
excessive length of stay or unspecified
diagnoses; they were considered "outliers."

Review of the QAPI program and COW meeting
minutes dated January 2017 through April 2017
indicated the Committee members did not
discuss the concerns identified relative to the lack
of a UR Committee and they did not discuss the
"outliers" which were identified through the
"Diagnostic Threshold/Outlier Days for
December, January and February Admissions"
dated 12/16/16 through 3/20/17 to ensure that the
cconcerns would not continue in the future. Refer
to findings at A 0654.

A 283 482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY
IMPROVEMENT ACTIVITIES

(b) Program Data
(2) [The hospital must use the data collected to -
.....]

(ii) Identify opportunities for improvement and
changes that will lead to improvement.
(c) Program Activities
(1) The hospital must set priorities for its performance improvement activities that--
   (i) Focus on high-risk, high-volume, or problem-prone areas;
   (ii) Consider the incidence, prevalence, and severity of problems in those areas; and
   (iii) Affect health outcomes, patient safety, and quality of care.

(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.

This STANDARD is not met as evidenced by: Based on interview, record review, and review of the facility's policies and procedures, the facility failed to ensure their Quality Assurance and Performance Improvement (QAPI) Committee had an ongoing program that included measurable improvements and outcomes for identified concerns. The QAPI Committee did not analyze and track indicators relative to the Food Service Department or the Infection Control Program. Consequently, the QAPI Committee did not develop plans of actions with measurable goals and timetables to ensure these concerns would not continue in the future. This deficient practice had the potential to affect all of the patients who received services through this facility.

Findings include:
### Statement of Deficiencies and Plan of Correction

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<tr>
<td>1. Review of the facility's undated policy titled, &quot;Quality Assurance Program&quot; indicated the Food Service Department was responsible to implement and maintain a Quality Assurance (QA) Program that defines, measures, and evaluates quality in the delivery of Food Services. The QA Program was an integrated part of the overall facility QA Program and designed to regularly evaluate the quality and effectiveness of food service to patients. The policy stated the Food Service Director (FSD) was responsible for implementing and assuring the QA Program for the Food Service Department. The QA Program of the Food Service Department included evaluations related to dining environment, food production, nutritional assessments, food acceptance, sanitation and safety, food temperature, monitoring special diets of patients, nutrition-at risk interventions, and documentation. The QA Program further indicated the FSD assumed the overall responsibility for the implementation and monitoring of the QA Program for the Food Service Department.</td>
<td>A 283</td>
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<td>An interview with the Food Service Director (FSD) on 5/8/17 at 9:40 a.m. revealed that the Food Service Department was a contracted service for the facility. The patients' meals were prepared in the main kitchen which was located across the street from the facility. The FSD stated the employees that worked in the main kitchen were employed by the contract company, not the facility. She added that the contract company followed 2 sets of policies and procedures; theirs and the policies and procedures of the facility.</td>
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<td>Observation of the main kitchen on 5/8/17 from 9:40 a.m. through 10:15 a.m. revealed the kitchen was not maintained in a safe and sanitary</td>
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A 283 Continued From page 8

fashion. The metal blades on the Robot Coupe (food blender) were chipped and cracked. The meat slicer was not cleaned and sanitized after use and the food chute end weight was rusted and missing paint. The dish machines were not operating per the manufacturer's recommendations. The freezer was not holding at 0 degrees Fahrenheit (F) and had water dripping from the ceiling and a broken fly curtain (plastic strips). The cold refrigerated foods were not monitored for time and temperature for safe storage.

Observation on 5/10/17 at 11:30 a.m. of Unit 1 and Unit 2 of the facility revealed the staff delivered food to the patients 3 times each day from the main kitchen across the street.

During an interview on 5/10/17 at 11:45 a.m. about who maintained the small kitchens on the facility Units, the Registered Nurse Supervisor stated they had a sanitation form which was to be completed on a daily basis.

An interview with the Infection Control Nurse on 5/11/17 at 11:00 a.m. revealed the staff were to inspect the small kitchens in Unit 1 and Unit 2 on a daily basis. She stated the staff inspect the kitchens at least twice each day and document their findings on the "Patient Kitchen Inspection Report."

Review of the "Patient Kitchen Inspection Report(s)" dated 3/3/17 through 5/4/17 indicated the facility staff had identified some concerns when inspecting the small kitchens in both Unit 1 and Unit 2. Further review of the "Patient Kitchen Inspection Report(s)" provided the following information:
A 283 Continued From page 9

a. Inspection report dated 3/3/17: the kitchen drawers were left open and the snacks did not have expiration dates.

b. Inspection report dated 3/6/17: the coffee condiments were left opened, the snacks did not contain expiration dates, and the cleaning of the refrigerator was not documented.

c. Inspection report dated 3/7/17: the bulk storage food items were not individually dated.

d. Inspection report dated 3/10/17: the refrigerator was in need of cleaning.

e. Inspection report dated 3/11/17: the snacks were not individually dated.

f. Inspection report dated 3/13/17: the snacks did not contain an expiration date.

g. Inspection report dated 3/14/17: the cheese and graham crackers were not dated, the bulk storage foods were not individually dated, food and dirty spoons were found on the floor, and there were 4 boxes of lunch trays on the counter.

h. Inspection report dated 3/15/17: the bulk items were not individually dated.

i. Inspection report dated 3/21/17: there were 12 milk cartons that were expired.

j. Inspection report dated 3/22/17: coffee grounds were found on the countertop, an open package of towels was found on the top of the refrigerator, and the meal trays had not been dumped.
A 283 Continued From page 10

k. Inspection report dated 3/27/17: the ice machine had some deposits on the bottom, the snacks did not have an expiration date, the meal trays were not cleaned, the dry storage food packages were not dated, and coffee had been spilled in the refrigerator.

l. Inspection report dated 3/30/17: there was a personal knife found in the refrigerator, the floors, drawers, and cabinets needed to be cleaned, and the outside of the refrigerator was visibly soiled.

m. Inspection reports dated 4/5/17, 4/6/17, and 4/13/17: the galley snacks did not contain an expiration date.

n. Inspection report dated 4/18/17: the galley snacks did not contain an expiration date, the floor was soiled, the drawers were open, and the water dispenser was visibly soiled.

o. Inspection report dated 4/20/17: the refrigerator and the drawers needed to be cleaned and the galley snacks did not contain an expiration date.

p. Inspection report dated 4/26/17: the galley snacks did not contain an expiration date.

q. Inspection report dated 4/27/17: the two lower cabinets needed to be cleaned, there was some build up in the water dispenser, and the galley snacks did not contain an expiration date.

r. Inspection report dated 4/28/17: there was a soiled rag on the counter and the galley snacks did not contain an expiration date.

s. Inspection report dated 5/4/17: the sink was
A. BUILDING ____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

H061002

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ____________________________

B. WING ________________________________

(X3) DATE SURVEY COMPLETED

05/12/2017

NAME OF PROVIDER OR SUPPLIER

ADAIR ACUTE CARE AT OSAWATOMIE STATE HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

500 STATE HOSPITAL DRIVE

OSAWATOMIE, KS 66064

(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

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<td>soiled and the galley snacks did not contain an expiration date.</td>
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Review of the Quality Assurance Performance Improvement (QAPI) meeting minutes dated January 2017 through April 2017 indicated that the "Patient Kitchen Inspection Reports" had not been discussed, consequently the concerns were not identified to ensure the committee members could develop a plan of action with measurable goals and time tables to ensure the concerns would not continue in the future.

An interview with the QAPI/Risk Manager and the Chief Medical Officer (CMO) on 5/9/17 at 1:30 p.m. confirmed that neither the facility's QAPI team nor the Committee of the Whole (COW) provided oversight of the contracted Food Service Department and they did not discuss the findings identified on the "Patient Kitchen Inspection Reports." When interviewed about how the facility could identify concerns in the main kitchen and in the small kitchens on Units 1 and 2 if they did not oversee the departments, the QAPI/Risk Manager and the CMO stated they could not.

Review of the facility's policy and procedure titled, "Quality Assessment Performance Improvement Program," dated 7/29/16, provided the following information:

*I. Policy

This hospital's quality assessment and performance improvement (QAPI) program will:

Reflect the complexity of the hospital's programs and services.
### SUMMARY STATEMENT OF DEFICIENCIES

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**Involve all hospital departments and services (including those furnished under contract or arrangement).**

Focus on indicators related to improved health outcomes as well as the prevention and reduction of medical errors.

This is done through developing, implementing, and maintaining an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program ...

**B. Data Collection and Analysis**

All hospital departments and services (including those furnished under contract or arrangement) will be involved in the hospital's QAPI program ...

b. For those services provided through contractual agreements, the Department Head or designee responsible for oversight for the services of the contract will work with the contractor to develop QAPI measures and identify opportunities for improvement."

2. Review of patient # 24 and 25's medical record indicated the two were roommates. On 3/15/17 patient 25's throat culture tested positive for "Group A Streptococcus (bacterium found in the human throat or on the skin which many cause many different infections, including strep throat and scarlet fever)" and two days later on 3/17/17, patient 24's throat culture tested positive for "Group A Streptococcus."

Review of patient # 26's medical record showed the patient tested positive for Clostridium difficile (bacterial infection that requires isolation...
Continued From page 13

precautions; and can cause symptoms ranging from diarrhea to life threatening inflammation of the colon) on 1/24/17. Further documentation on 1/30/17 showed a physician order discontinuing the patient's "medical isolation." On 2/8/17 the physician directed staff to return the patient to "contact isolation" after another stool sample was again positive for C-diff toxin.

Review of the facility's Infection Control Policies and Procedures on 5/10/17, showed they did not include information related to "contact isolation measures." On 5/10/17 at 8:40 am, the Infection Control Nurse and Medical Director confirmed the facility had no isolation policies.

Review of the "(Facility name), Infection Control Reports" sent to the QAPI Committee indicated the report contained identified healthcare associated infections (HAIs). However, further review of the "(Facility name), Infection Control Reports" for February 2017 and March 2017 indicated no action plans were developed for the investigation into how the HAIs for Patients # 24, 25, or 26 were acquired or the need to develop isolation policies specific to the facility.

During an interview on 5/10/17 at 8:40 a.m., the Infection Control Nurse and Medical Director both acknowledged that the QAPI Committee lacked a plan for investigations of HAIs acquired during a patient's hospitalization.

(1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or
### A 405 Continued From page 14

Practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.

(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.

This STANDARD is not met as evidenced by:

Based on observation, interview, record review, and review of policy and procedure, the facility failed to ensure the staff followed policies for after-hours medication orders and standards of practice in medication administration for 1 patient (Patient (P) 31) out of 4 patients observed during medication pass on 5/9/17.

Findings include:

Review of P31’s "Physician's Orders" indicated an order written on 5/8/17 at 6:30 p.m. for the staff to administer olanzapine (an antipsychotic medication for treatment of schizophrenia and bipolar disorder) 5 milligrams (mg) orally at 8:00 a.m.

Observation of medication pass on 5/9/17 at 9:15 a.m. revealed the patient's olanzapine 5
A 405 Continued From page 15

mg medication was not in the medication cart for the nurse to set up and administer to the patient. Rather than following policy and getting the medication from the pharmacy storage, the Licensed Practical Nurse (LPN) "borrowed" the medication from another resident's supply.

During an interview on 5/9/17 at 2:45 p.m., the pharmacist stated the Registered Nurse (RN) who worked as the charge nurse on the night of 5/8/17 should have filled the order as the pharmacy was closed. The pharmacist added that "borrowing" medications from other patients was not a standard of practice at the facility.

During an interview on 5/10/17 at 9:30 a.m., the DON confirmed the RN who worked as the charge nurse on the night of 5/8/17 should have filled the order as the pharmacy was closed. The DON stated that "borrowing" medications from other patients was not a standard of practice at the facility.

Review of the facility's pharmacy policy and procedure titled, "MM6.1 After Hour Pharmacy Operations," provided the following information:

"After regular Pharmacy operational hours, a Registered Nurse (RN) will be designated to obtain medications from the After Hours Pharmacy for bedside administration."

A 528 482.26 RADIOLOGIC SERVICES

The hospital must maintain, or have available, diagnostic radiological services. If therapeutic services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel
A 528 Continued From page 16

qualifications. This CONDITION is not met as evidenced by:
Based on and interview and record review, the facility failed to meet the Condition of Participation (CoP) for radiological services. The facility did not provide on-site radiological services and had no contractual arrangement with an off-site facility to provide radiological services for its patients. This deficient practice had the potential to affect all of the patients who receive services through this hospital.

Findings include:

Review of the "Hospital/CAH (critical access hospital) Database Worksheet" Exhibit 286, dated 5/8/17, indicated the hospital provided no radiological services. Under the "M41" section of the worksheet, the facility documented a "0" in the space for radiological services.

During an interview on 5/9/17 at 1:30 p.m., the Chief Medical Officer (CMO) stated that the hospital did not have an "agreement" with an outside vendor nor did the hospital offer radiological services on the premises. The CMO stated if a patient required radiological services, the hospital staff would either have the patient transported to a larger hospital or call for a mobile radiological unit.

A 618 482.28 FOOD AND DIETETIC SERVICES

The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel. However, a hospital that has a contract with an outside food management company may be found to meet this Condition of Participation if the company has a
## A. BUILDING ________

### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
- **STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>05/12/2017</th>
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### NAME OF PROVIDER OR SUPPLIER
- **ADAI ACUTE CARE AT OSAWATOMIE STATE HOSPITAL**
- **STREET ADDRESS, CITY, STATE, ZIP CODE**
  - 500 STATE HOSPITAL DRIVE
  - OSAWATOMIE, KS  66064

### SUMMARY STATEMENT OF DEFICIENCIES

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<td>A 618</td>
<td>Continued From page 17 dietitian who serves the hospital on a full-time, part-time, or consultant basis, and if the company maintains at least the minimum standards specified in this section and provides for constant liaison with the hospital medical staff for recommendations on dietetic policies affecting patient treatment. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to meet the Condition of Participation (CoP) for Food and Dietetic Services when the facility failed to ensure contracted kitchen employees received sufficient training to enable them to perform their duties in a safe and sanitary manner. The facility also failed to ensure the Food Service Director was well organized and could maintain the kitchen in a safe and sanitary fashion. This deficient practice had the potential to affect all patients who received food services through this hospital. Findings include: 1. During an interview on 5/8/17 at 9:40 a.m., the Food Service Director (FSD) stated that the Food Service Department was a contracted service for the hospital. The main kitchen, located across the street from the hospital, prepared and served all the meals to the patients in the hospital. The FSD stated that the employees who worked in the main kitchen were employed by the contract company, not the hospital. She added that the contract company followed 2 sets of policies and procedures, theirs, and the policies and procedures of the hospital. Observation and interview, and a review of employees’ personnel files, in-service training</td>
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### Summary Statement of Deficiencies

**A 618** Continued From page 18

Records, and the contract between the Food Service Company and the Hospital, the facility failed to ensure that the contracted kitchen employees had sufficient training to perform their food service responsibilities and duties in a competent manner. Refer to findings at A 0622.

1. Observation of the main kitchen on 5/8/17 from 9:15 a.m. to 11:15 a.m. showed the kitchen environment was not safe and sanitary, essential equipment was not maintained in a clean, safe and fully functional manner, staff were not properly trained in food service activities, and potentially hazardous foods were not properly stored to prevent foodborne illness. Refer to findings at A 0749.

### Provider's Plan of Correction

**A 622** 482.28(a)(3) COMPETENT DIETARY STAFF

There must be administrative and technical personnel competent in their respective duties.

This STANDARD is not met as evidenced by:

Based on review of employees' personnel files, in-service training records, review of the contract between the Food Service Company and the Hospital, interview, and observation, the facility failed to ensure that contracted kitchen employees had sufficient training to perform their food service responsibilities and duties in a competent manner. This deficient practice had the potential to affect all of the patients who received food services through this hospital.

Findings include:

1. Review of the contract between the Food Service Company and the Hospital, dated 8/25/16, revealed the following information:
A 622 Continued From page 19

"...Contractor shall provide for training as per its proposed staff development program; In-service training shall be provided once per month; Contractor shall comply with hospital training requirements including security concerns and unique needs of the hospitals' consumers, dealing with special diets, safely, hazardous materials handling, and infection control; each employee's (sic) shall complete and be certified in ServSafe training within three (3) months of hire..."

Review of the personnel files on 5/9/17 at 10:00 a.m. for the contracted kitchen employees indicated that 10 of the 23 employees had not been "ServSafe" trained. The following employees did not have the necessary training:

a. Dietary Aide (DA) 1 was hired on 6/25/15 and was not ServSafe trained.

b. DA 2 was hired on 7/2/15 and failed the test. DA 2 had not re-taken the exam.

c. Cook 1 was hired on 7/18/13. Cook 1's ServSafe training had expired.

d. Preparation Cook was hired on 9/10/13 and was not ServSafe trained.

e. DA 3 was hired on 2/11/16 and was not ServSafe trained.

f. DA 4 was hired on 7/26/16 and was not ServSafe trained.

g. DA 5 was hired on 10/29/16 and was not ServSafe trained.
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<td>h.</td>
<td>DA 6 was hired on 7/23/16 and was not ServSafe trained.</td>
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<td>i.</td>
<td>DA 7 was hired on 4/4/16 and was not ServSafe trained.</td>
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<td>j.</td>
<td>Cook 3 was hired on 10/19/16 and was not ServSafe trained.</td>
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An interview with the Chief Medical Officer (CMO) and the District Manager on 5/9/17 at 10:30 a.m. confirmed that it was the policy of the contracted Food Service Company to ensure that each employee had been properly trained within 3 months of hire. When interviewed about why 10 of the 23 employees' reviewed had not completed the training to ensure they could prepare food safely, the District Manager stated he did not know.

Review of the in-service trainings provided to the contracted kitchen staff from 8/2016 through 3/2017 indicated only 3 of the trainings were related to safe food production. An in-service training provided on 4/2/17 provided instruction on receiving and storing food safely. However, of the 23 contracted kitchen employees, only 4 attended the in-service training.

Review of the in-service training provided to the kitchen staff on 3/21/17 indicated the topic of the training was related to labeling and date marking. Review of the attendance record and signature sheet revealed that only 5 of the 23 employees attended the training.

Review of the in-service training provided on 1/4/17 indicated the training was a duplicated...
A 622 Continued From page 21

in-service training from 12/2016 with the topic of preventing cross-contamination. However, only 19 of the 23 employees attended the training.

The remaining 9 in-service training programs provided since 8/2016 covered topics such as lifting safely, accident prevention, allergies etc. None were food production and food safety related.

2. Observation of the lunch meal preparation on 5/8/17 at 11:10 a.m. revealed Cook 1 prepared to take and record the temperatures of the ready to eat food. Cook 1 was unable to calibrate the thermometer to 32 degrees Fahrenheit (F) in ice water because she did not have enough ice in the container. When Cook 1 placed the thermometer into the food she failed to first sanitize the probe. She then allowed the plastic housing to come in contact with the ready to eat food, which had not been sanitized. In addition, Cook 1 placed the probe through many pieces of steak fingers, rather than placing the thermocouple through the side of the steak finger to ensure that the center portion had reached a safe temperature. When Cook 1 began to prepare the mechanically altered food, she utilized a Robot Coupe with a chipped metal blade that was missing metal pieces. When interviewed about why she utilized a Robot Coupe to grind and blend the patients’ food if she was aware the metal pieces might enter the food, Cook 1 stated, “Because this is all we have.”

3. Observation of the steam table on 5/8/17 at 11:15 a.m. revealed the food was ready for service and staff had already taken and recorded the food temperatures. An interview with Dietary Aide (DA) 9 revealed she had not taken the
### Summary Statement of Deficiencies

**A 622** Continued From page 22

The temperature of the ground steak fingers. DA 9 stated that Cook 1 told her what temperature to document on the temperature log. Review of the log titled, "Food Temperature Record at the Steamtable" indicated DA 9 had recorded the ground steak fingers at 185 degrees F. The temperature of the steak fingers was re-taken at that time and registered 142 degrees F. Review of the temperature log indicated the facility's policy directed the staff to ensure all ground foods had a safe holding temperature of 151 degrees F or warmer.

An interview with the FSD and the Chief Medical Officer (CMO) on 5/8/17 at 11:30 a.m. confirmed that the staff were to take and record each food temperature on the steam table before being served. The FSD added that DA 9 was a fairly new employee and she had not been ServSafe trained.

**A 654** 482.30(b) Utilization Review Committee

A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1).

(1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following:

- (i) A staff committee of the institution;
- (ii) A group outside the institution--
  - (A) Established by the local medical society and some or all of the hospitals in the locality; or
  - (B) Established in a manner approved by CMS.
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(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section.

(3) The committee or group's reviews may not be conducted by any individual who--
   - (i) Has a direct financial interest (for example, an ownership interest) in that hospital; or
   - (ii) Was professionally involved in the care of the patient whose case is being reviewed.

This STANDARD is not met as evidenced by:

Based on record review, interview, and review of policies and procedures, the facility failed to form a Utilization Review (UR) Committee to ensure that each patient who had the potential to be a Medicare and Medicaid Beneficiary would be evaluated for: Admission, length of stay, and professional services. This deficient practice had the potential to affect all patients who might be entitled to receive services under the Medicare and Medicaid program.

Findings include:

1. During an interview conducted on 5/11/17 at 9:40 a.m. with the Utilization Review (UR) Director and the CMO, they explained that the hospital did not have any UR Committee meetings because they did not have the professional staff to fill the required positions to form a Committee. When interviewed about how the facility implemented the UR plan which included a comprehensive review of the medical records for the "outliers" if they did not have a UR Committee, the UR Director and the CMO stated,
## Summary Statement of Deficiencies

### A. 654 Continued From page 24
they could not.

Review of the facility's policy and procedure titled, "Utilization Review Plan" dated 9/6/16, provided the following information:

"Policy

I. The Utilization Review Plan provides for review of admissions to (Name of the facility) for medical necessity. This includes review of duration of stay and professional series furnished to patients....

II. Procedure

A. The Utilization Review Committee is responsible for implementing, monitoring, and evaluating the effectiveness of the Utilization Review Plan.

1. The Utilization Review Coordinator reviews cases for the following requirements:

   a. Certification and recertification of need for inpatient care
   
   b. Medical, psychiatric, and social evaluations
   
   c. Individual written plan of care

2. The Utilization Review Coordinator reports to the Committee of the Whole on at least a monthly basis for review of:

   a. Cases that do not meet the above requirements (see above: A, 1, a, b, and c);
   
   b. Stays that exceed outlier thresholds for the diagnostic groups (See Appendix II);
**A. BUILDING**

**H061002**

**NAME OF PROVIDER OR SUPPLIER**

**ADAIR ACUTE CARE AT OSAWATOMIE STATE HOSPITAL**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**500 STATE HOSPITAL DRIVE**

**OSAWATOMIE, KS  66064**

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

**H061002**

#### (X2) MULTIPLE CONSTRUCTION

**A. BUILDING**

**B. WING**

#### (X3) DATE SURVEY COMPLETED

**05/12/2017**

#### (X4) ID PREFIX TAG

#### ID PREFIX TAG

#### PROVIDER’S PLAN OF CORRECTION

**EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY**

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**SUMMARY STATEMENT OF DEFICIENCIES**

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

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<td>c.</td>
<td>d.</td>
<td>Professional services provided that exceed the reasonably assumed amount;</td>
<td>Cases where private insurance denies coverage based on their determination that the provided information lacks medical necessity.</td>
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### 3. Utilization Review Committee membership and functions include:

1. The Utilization Review Committee membership includes staff from the following areas:

   a. Pharmacy Services
   b. Business Services
   c. Medical Staff - 2 physicians
   d. Nursing Services

2. The Committee review may not be conducted by any individual who:

   a. Has a direct financial interest in any mental hospital.
   b. Is professionally involved in the care of patient whose case is being reviewed.

4. All Utilization Review Committee minutes will include dates, members in attendance, extended stay and outlier professional services reviewed with approval and/or disapproval noted in a status report including any actions taken.

5. The Utilization Review Committee will update Appendix II each fiscal year to determine the
A 654 Continued From page 26 threshold for the diagnostic groups...."

Review of the reports titled, "Diagnostic Threshold/Outlier Days for December, January and February Admissions" (which are documented a month in the arrears) dated 12/16/16 through 3/20/17, indicated that each month the hospital had patients whose medical records required a comprehensive review by the UR Committee due to excessive length of stay or unspecified diagnoses; they were considered "outliers." The diagnostic reports provided the following information:

1. Review of the report for the December 2016 admissions indicated the hospital had 13 "outliers" for which a comprehensive review was necessary per the UR policy and procedure.

2. Review of the report for the January 2017 admissions indicated the hospital had 5 "outliers" for which a comprehensive review was necessary per the UR policy and procedure.

3. Review of the report for the February 2017 admissions indicated the hospital had 10 "outliers" for which a comprehensive review was necessary per the UR policy and procedure.

During an interview conducted on 5/11/17 at 9:40 a.m., the Utilization Director and the Chief Medical Officer (CMO) were asked to provide the Utilization Review Committee meeting minutes so the meeting could be evaluated for dates, members in attendance, and how they assessed each "outlier" and what actions were taken. The Utilization Director and the CMO stated that they did not have any UR Committee meetings because they did not have the professional staff...
A. BUILDING ________________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

H061002

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

05/12/2017

NAME OF PROVIDER OR SUPPLIER

ADAIR ACUTE CARE AT OSAWATOMIE STATE HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE

500 STATE HOSPITAL DRIVE

OSAWATOMIE, KS  66064

(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

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<td>to fill the required positions. When asked how the facility implemented the UR plan which included a comprehensive review of the medical records for the &quot;outliers&quot; if they did not have a UR Committee, the UR Director and the CMO stated they could not. When asked how the facility ensured that each patient's medical record was reviewed for medical necessity and professional services if they did not have a UR Committee, the UR Director stated the facility discussed the &quot;outliers&quot; during the Committee of the Whole (COW) on a monthly basis. However, the COW Committee members did not include 2 physicians who were not professionally involved in the care of the patients being reviewed.</td>
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<td>A 747</td>
<td>482.42 INFECTION CONTROL</td>
<td>The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview, and record review, the facility failed to meet the Condition of Participation (CoP) for Infection Control. The facility failed to ensure the food service department contractor: - maintained food at proper holding temperatures to reduce the rapid and progressive growth of illness producing microorganisms; - monitored food temperatures and functioning of the refrigeration equipment; - properly stored emergency food supplies to maintain integrity of the packaging and food; - properly maintained, washed and sanitized food</td>
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### Summary Statement of Deficiencies

#### A. Based on observation, interview, and record review, the facility failed to ensure the food service department contractor properly maintained, washed and sanitized food service equipment and eating utensils to prevent foodborne illness. This deficient practice had the potential to affect all of the patients who received services through this facility.

**Findings include:**

1. Observation of the main kitchen on 5/8/17 from 9:40 a.m. until 10:15 a.m. revealed the hospital maintained two dish rooms. One of the dish rooms had a dish machine utilized for cleaning and sanitizing pots and pans, and the other dish room had a dish machine utilized for cleaning and sanitizing dishware. Review of the manufacturer's recommendations for use (posted on a label that was affixed to each dish machine), revealed that the minimum water temperature during the wash cycle needed to reach 150 degrees Fahrenheit
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<td>(F) and the water temperature for the sanitizing cycle needed to reach a minimum of 180 degrees F for food safety.</td>
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Observation of the dish machines in operation for 2 separate trials on each machine, revealed that the water in the rinse/sanitizing cycle did not reach a minimum of 180 degrees F; it reached 170 degrees F for both trials and on both dish machines. In addition, fuzzy debris covered the vent located at the top of the dish machine.

Review of the "Pot and Pan Machine Record Log," dated May 2017, revealed the staff had not documented the water temperature for the wash water or the sanitizing water before cleaning and sanitizing the pots and pans on 5/8/17.

Review of the "Dishwasher Record Log," dated May 2017, revealed the staff had not documented the water temperature for the wash water or the sanitizing water before cleaning and sanitizing the patients' dishware on 5/8/17.

Review of the facility's undated policy, "Dishwashing Temperature Monitoring Logs" indicated a log must be completed by those who are directly involved in the dishwashing process and entries must be made daily according to health department regulations and quality assurance standards to ensure wash and rinse temperatures and sanitizing chemicals are properly monitored and controlled.

Review of the facility's policy titled, "Dishwashing Procedures," dated 12/11/08, indicated dishwashing operation will provide proper separation in the handling of soiled and clean dishes/utensils and will confirm with the following...
A 749 Continued From page 30
procedures for washing, rinsing, sanitizing, and
drying according to state and federal regulations.
The policy further stated the dishwashing
machine will be operated in accordance with the
manufacturer's instructions and the temperature
of the water shall be maintained at 150 degrees F
or above for the washing cycle and at 180
degrees F for the rinsing and sanitizing cycle.

An interview with the Director of Operations, the
Food Service Director (FSD), the Chief Medical
Officer (CMO), and Dietary Aide (DA) 8 revealed
that it was the hospital's policy to take and record
the water temperature in each dish machine
before use to ensure food safety. When
interviewed about why he did not take and record
the water temperatures before use on 5/8/17, DA
8 stated he was unsure. The FSD stated that staff
had already utilized the dish machines to clean
the pots and pans and the dishware used to
prepare the patients breakfast on 5/8/17. When
interviewed about how she could ensure food
safety if the water temperature in the sanitizing
cycle had not reached a minimum of 180 degrees
F per the manufacturer's recommendations, the
FSD stated she could not.

2. On 5/8/17 from 9:40 a.m. until 10:15 a.m.,
observation of the meat slicer located in the main
kitchen revealed it sat on a food preparation
counter, assembled but was not in use. Closer
inspection of the meat slicer revealed there was
food debris on the blade and under the blade
cover. The food chute end weight (the part that
holds the meat close to the blade and protects
the operator's hand) was rusted and missing
paint, creating an unsanitizable surface as well as
the potential for rust and paint flecks to
contaminate the patient's food. The FSD stated
A 749 Continued From page 31
that the meat slicer had not been utilized on
5/8/17. She added that staff had used it the
previous day to slice meat and they should have
cleaned and sanitized it after use and before
re-assembling the parts to ensure food safety.

3. Observation on 5/8/17 from 9:40 a.m. until
10:15 a.m. revealed the 4 Robot Coupes (food
blenders) had metal blades that were chipped,
cracked and missing pieces, creating an
unsanitizable surface and safety hazard.
Observation of food production revealed Cook 1
prepared to grind and blenderize the steak fingers
for those patients who required a mechanically
altered diet per physician's order. Cook 1 utilized
the Robot Coupe with the cracked and chipped
blade.

During an interview on 5/8/17 at 11:00 a.m., Cook
1 stated that she utilized the Robot Coupe to
chop and blenderize some of the patients’ food.
When interviewed about why the surface of the
metal blades were compromised and missing
pieces, Cook 1 stated she was unsure. When
interviewed about why she would continue to use
the Robot Coupe with a cracked and chipped
blade, Cook 1 stated, "Because the hospital does
not have any other way to chop and grind the
patients’ food.”

During an interview on 5/8/17 at 11:00 a.m., the
FSD confirmed that she had not monitored or
sharpened the metal blades in the Robot Coupes
since her employment at this facility which was
approximately 3 years. The FSD added that she
was unsure where the missing metal pieces were
or if they had ended up in the patients’ food.

4. Observation of the lunch meal preparation on
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5/8/17 at 11:10 a.m. revealed Cook 1 prepared to take and record the temperatures of the ready to eat food. Cook 1 was unable to calibrate the thermometer and could not demonstrate safe use of the thermometer. Cook1 could not calibrate the thermometer to 32 degrees Fahrenheit (F) in ice water because she did not have enough ice in the container. When Cook1 placed the thermometer into the food, she failed to sanitize the probe and allowed the plastic housing to come in contact with ready to eat food.

B. Based on observation, interview, and record review, the facility failed to ensure the food service department contractor maintained frozen and refrigerated food at proper holding temperatures to reduce the rapid and progressive growth of illness producing microorganisms. In addition the facility failed to properly cool potentially hazardous foods in order to prevent foodborne illness (meat, fish, poultry, eggs, dairy, etc. are potentially hazardous foods that require time and temperature control to prevent bacteria growth).

Findings include:

1. Observation of the steam table in the main kitchen on 5/8/17 at 11:15 a.m. revealed the food was ready for service and the staff had already taken and recorded the food temperatures. Review of the log titled, "Food Temperature Record at the Steamtable" indicated Dietary Aide (DA) 9 recorded the ground steak fingers at 185 degrees F. The temperature of the steak fingers was re-taken and registered 142 degrees F. Review of the temperature log indicated the facility's policy directed the staff to ensure all ground foods had a safe holding temperature of
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Adair Acute Care at Osawatomie State Hospital  
**Street Address, City, State, Zip Code:** 500 State Hospital Drive, Osawatomie, KS 66064  

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<th>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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151 degrees F or warmer.  
An interview with the Food Service Director (FSD) and the Chief Medical Officer (CMO) on 5/8/17 at 11:30 a.m. revealed the food service employees were responsible for recording food temperatures prior to the service of food on the steam table. The FSD further stated DA 9 was a new employee.  
2. Observation of the small kitchens on Units 1 and 2 on 5/10/17 at 11:45 a.m. revealed the staff delivered lunch meals to the patients on individual trays and the food came from the main kitchen. When asked to take the food temperatures before serving the food the Registered Nurse (RN) Supervisor stated the kitchens on the Units did not have a thermometer. The RN Supervisor stated she had been employed at the facility for approximately 8 months and during that time she had not taken or recorded the food temperatures when delivered to the patients from the main kitchen. A calibrated thermometer was retrieved from the main kitchen and the food temperatures were taken at 11:55 a.m. The carrot and raisin salad was holding at 58 degrees F.  
Observation of the main kitchen on 5/10/17 at 12:15 p.m. revealed a large 1-gallon bucket of carrot and raisin salad sat next to the serving line and was not placed on ice. The temperature of the salad was taken and registered 54 degrees F.  
Review of the facility log titled, "Food Temperature Record at the Steamtable," dated May 2017, indicated cold salads were to be held and served at 41 degrees F or below.  
An interview with the FSD on 5/10/17 at 12:20 | A 749 | | |
A 749 Continued From page 34
p.m. confirmed that the carrot raisin salad being held in the one-gallon bucket was the same carrot raisin salad that was served to the patients on both Units 1 and 2. She stated that the salad had been prepared some 4 hours earlier and it should have been held at or below 41 degrees F to ensure food safety.

3. Observation of the walk-in refrigerator in the main kitchen on 5/8/17 from 9:15 a.m. to 11:15 a.m. revealed 12 large and deep metal pans that contained left-over foods. Review of the food labels that were stuck to the metal lids revealed they did not include a time or a temperature. When interviewed about what time the left-over foods were placed in the refrigerator, the FSD stated she was unsure, but she stated it was the night previous. When interviewed about how the facility could ensure that the left-over foods had cooled in a timely fashion if they did not monitor the cooling time, the FSD stated she could not.

Review of the facility's policy and procedure titled, "Cooling Potentially Hazardous Foods," dated 5/2008, provided the following information:

*Purpose: To prevent foodborne illness by ensuring that all potentially hazardous foods are cooled properly....

Procedures:
- Train food service employees who prepare or serve food on how to use a food thermometer and how to cool foods using this procedure.
- Modify menus, production schedules, and staff workhours to allow for implementation of proper cooling procedures.
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<td>- Prepare and cool food in small batches.</td>
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<td>- Chill food rapidly using an appropriate cooling method:</td>
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<td>- Break food down into smaller amounts (no more than 2 inches in depth) and place food in shallow containers (no more than 4 inches deep).</td>
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<td>- Stir food frequently prior to placing the pan(s) in the cooler to allow for the cooling process to begin.</td>
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<td>- Place uncovered shallow pans on the top shelf in the back of the walk-in or reach-in cooler.</td>
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<td>- Use a quick-chill unit such as a blast chiller.</td>
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<td>- Chill cooked, hot food from:</td>
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<td>- 140 degrees F to 70 degrees F within 2 hours. Take corrective action immediately if food is not chilled from 140 degrees F to 70 degrees F within 2 hours.</td>
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<td>- 70 degrees F to 41 degrees F or below in remaining time. The total cooling process from 140 degrees F to 41 degrees F may not exceed six hours. Take corrective action immediately if food is not chilled from 140 degrees F to 41 degrees F within the 6-hour cooling process.</td>
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<td>- Use a clean, sanitized, and calibrated probe thermometer to measure the internal temperature of the food during the cooling process as a part of the Sanitation and Safety checklist.</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

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<th>A 749</th>
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- Monitor that proper cooling methods are used...

4. Observation of the main kitchen's walk-in freezer on 5/8/17 from 9:15 a.m. until 11:15 a.m. revealed water dripped from the entire ceiling from the front of the freezer to the back. The outside temperature gauge on the freezer read 20 degrees F. When interviewed about why the freezer was holding at 20 degrees F (rather than 0 degrees F to ensure the food would remain in a frozen state) and had water dripping from the ceiling, the FSD stated she was unsure.

C. Based on observation and record review, the facility failed to properly store emergency food supplies to maintain integrity of the packaging and food in order to prevent foodborne illness.

1. Observation of the emergency food supply, which was stored in a locked room, on 5/9/16 at 2:00 p.m. revealed the room was dirty and the cold foods were not stored safely. The floors had water and dirt stains, the walls were stained, there was garbage thrown about, and there were dead pests and cob webs around the bottom of the door. The cold foods, which were stored in a reach-in refrigerator, were in cardboard boxes and not placed on shelves. The many cardboard boxes that contained loaves of bread and other potentially hazardous foods were stored on the bottom floor of the refrigerator. The cardboard boxes were piled on top of each other and they reached from the bottom to the top of the refrigerator. There was no space between the cardboard boxes to allow for air flow.

An interview with the FSD and the CMO on 5/9/16 at 2:00 p.m. revealed that the kitchen staff...
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<th>Facility ID: H061002</th>
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### Statement of Deficiencies

#### Name of Provider or Supplier

**ADAIR ACUTE CARE AT OSAWATOMIE STATE HOSPITAL**

**Address:**

500 STATE HOSPITAL DRIVE
OSAWATOMIE, KS  66064

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#### Deficiencies

**A 749 Continued From page 37**

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entered the emergency food supply storage room on a daily occasion; however, they had not taken the time to ensure that the room remained clean and sanitary. When interviewed about why the boxes of food were stored on the floor of the refrigerator and not on shelves to ensure food safety, the FDS stated she was unsure.

Per the Food and Drug Administration's (FDA) 2013 Food code, "In addition to keeping the temperature in your fridge at 40 degrees F, you can take additional steps to make sure your refrigerated foods stay as safe as possible. Avoid 'Over packing.' Cold air must circulate around refrigerated foods to keep them properly chilled."

Review of the facility's undated policy and procedure titled, "Cleaning Guidelines" provided the following information:

"A. Refrigerators and Freezers ..."

Food must be stored at 6 least (sic) inches above the floor to allow for easy cleaning access ..."

**D. Based on observation, interview, and record review, the facility failed to develop, implement, and evaluate measures governing the identification, investigation, controlling, and reporting of infections for 3 patients (Patient (P) 24, P 25, and P 26) of 30 sampled patients.**

Findings include:

1. Review of P 26's medical record showed the patient was diagnosed on 1/24/17 with Clostridium difficile (C. diff) infection (a bacterial infection that can cause symptoms ranging from diarrhea to life-threatening inflammation of the..."
Continued From page 38

colon) after having multiple episodes of loose stools. No order could be found for the patient to be placed in isolation due to the C-diff infection. However, an order dated 1/30/17 read, "DC (discontinue) Medical Isolation."

Review of a physician's order, dated 2/2/17, indicated the patient was to continue to use the Arjo Tub room for his bathroom and reside in a private room.

Review of a physician's order, dated 2/8/17, directed that the patient be returned to "Contact Isolation." The staff obtained another stool sample, which again, was positive for C-diff toxin.

a. On 5/10/17, a review of the facility's policies and procedures for "Infection Control" indicated the policies and procedures did not include information related to "Contact Isolation" measures.

b. A review of the "(Facility name), Infection Control Report, February 2017" indicated no documentation to show the facility investigated the etiology of P 26's C. diff infection.

2. The facility admitted P 24 on 2/7/17, and admitted P 25 on 2/16/17. P 24 and P 25 shared the same room. Review of a physician's order, dated 3/13/17, indicated the physician ordered a throat culture for P 25. The results of the throat culture, completed on 3/15/17, were reported as, "Group A Streptococcus." Review of a physician's order, dated 3/17/17, indicated the physician ordered a throat culture for P 24. The results of which were positive for "Group A Streptococcus." Group A Streptococcus (group A strep) is a type of bacterium that easily spreads wherever groups
A. BUILDING ______________________

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

H061002

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED

STREET ADDRESS, CITY, STATE, ZIP CODE

OSAWATOMIE, KS 66064

(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

ADAIR ACUTE CARE AT OSAWATOMIE STATE HOSPITAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER

Streptococcal Infections

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of people gather together and can cause many different infections that range from minor illnesses to very serious and deadly diseases, i.e., strep throat to scarlet fever.

a. Review of the Centers for Disease Control and Prevention (CDC) "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)" indicated patients with Group A Streptococcal infection be placed under "droplet precautions" (Infection is spread via tiny droplets in the air from the mouth or nose, necessitating healthcare workers wear mask, gown and gloves while in the patient's room).

Review of their medical records indicated P 24 and P 25 were both involved in Mental Health Programming and had contact with other patients in their Unit.

b. A review of the "(Facility name), Infection Control Report, March 2017" indicated no documentation to show the facility investigated the etiology of the Group A Streptococcal infection in both P 24 and P 25.

Review of the facility's policy and procedure titled, "IC -1.0 Infection Prevention and Control Program" indicated the policy outlined the data collection process utilized by the Infection Control Nurse. However, the program lacked policies and staff guidance for isolation precautions and for the prevention of cross-contamination. The program also lacked policies on the investigation, prevention, and reporting of findings when HAIs were identified.

During an interview on 5/10/17 at 8:45 a.m., the
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Infection Control Nurse and Medical Director both gave an opinion regarding how the HAIs occurred for P24, P25, and P26, but failed to have an investigation to validate the information. Both indicated they would develop a process for investigation and prevention. |  |
|  |  |  |  |  |  | A 749 |  |