STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	175376		02/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT STREET SABETHA, KS 66534

(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
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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

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.

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F 225	Continued From page 1 This Requirement is not met as evidenced by: The facility identified a census of 82 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to investigate and report an injury of unknown origin for one resident (#54). Findings included: - The Physician's Order Sheet dated 1/21/16 for resident #54 included diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The Quarterly Minimum Data Set (MDS) dated 1/27/16 noted a Brief Interview for Mental Status (BIMS) of 3 (indicated severely impaired cognition), required extensive assist with bed mobility, transfers, walking in corridor, dressing, and eating. He/she was totally dependent on staff for locomotion on and off of unit, toileting, and personal hygiene. He/she received scheduled pain medications and showed non-verbal signs of pain 3 to 4 days of 5. The Care Area Assessments (CAA) dated 8/11/15 noted the resident continued to decline in cognition. He/she needed cueing and reminding for everything. The Activities of Daily Living (ADL) CAA did not trigger. The care plan dated 1/28/16 noted staff was to speak slowly and clearly to the resident, and give the resident ample time to respond.	F 225		

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F 225	Continued From page 2 Review of the nurses' notes and Treatment Administration Record for February 2016 lacked evidence of the facility identified or provided treatment of any skin issue. Observation on 02/09/16 at 10:02 A.M. there was scabbed abrasion on the resident's right lower leg. Observation on 02/10/2016 at 7:49 A.M. direct care staff propelled the resident down the hall in a wheelchair. Interview on 02/10/16 at 4:17 P.M. direct care staff P stated he/she reported any skin changes to the nurse, and denied knowledge of the abrasion. Interview on 02/11/16 at 10:00 A.M. licensed nursing staff I stated he/she was unaware of the abrasion. He/she stated direct care staff was expected to pass on any new skin issues. Interview on 02/11/16 at 11:40 A.M. administrative nursing staff D stated he/she expected the direct care staff to report skin issues and expected licensed nursing staff to document on all skin issues. The clinical record lacked documentation of the abrasion on the right shin. The facility's undated "Resident Abuse, Neglect, Exploitation and Mistreatment" policy revealed employees of the facility were obligated to report all events which were suspicious for abuse. The facility failed to investigate and report an abrasion on the skin of this cognitively impaired	F 225		

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F 225	Continued From page 3 resident.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility identified a census of 82 residents. The sample included 13 residents. Based on observation, record review and interview, the facility failed to accurately reflect the status for 2 sampled residents (#14 and #54). Findings included:	F 278		

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F 278	Continued From page 4 - The Physician's Order Sheet dated 1/21/16 for resident #54 noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The Quarterly Minimum Data Set (MDS) dated 1/27/16 noted a Brief Interview for Mental Status (BIMS) of 3 (indicated severely impaired cognition) and required extensive assistance with eating. The Annual MDS dated 8/11/15 noted a BIMS of 4 (indicated severely impaired cognition) and was independent with eating. The Care Area Assessments (CAA) dated 8/11/15 noted the resident continued to declined in cognition. He/she needed cueing and reminding for everything. The Activities of Daily Living (ADL) CAA did not trigger. The ADL records dated 1/21/16 to 1/27/16 noted the resident ate independently with set up. Observation on 02/10/16 at 8:09 A.M. the resident was served breakfast. Staff cued the resident to eat. He/she fed himself/herself without difficulty. Observation on 02/10/16 at 11:46 A.M. the resident was served lunch. Staff provided set up and cued resident to eat. He/she fed himself/herself without difficulty. Interview on 02/10/16 at 4:14 P.M. direct care staff P stated the resident was able to feed himself/herself, but needed frequent cues and prompting to eat.	F 278		

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F 278	Continued From page 5 Interview on 02/11/16 at 9:58 A.M. licensed nursing staff I stated the resident was able to feed himself/herself, but needed cueing and prompting. He/she said the MDS staff was responsible for accurate MDS information. Interview on 02/11/16 at 11:21 MDS staff E stated he/she retrieved the information for ADLs from the direct care staff's charting. Interview on 02/11/16 at 11:40 A.M. administrative nursing staff D stated he/she expected the MDS information to accurately reflect the resident. The facility failed to provide a MDS accuracy policy. The facility failed to accurately assess the eating ability for this cognitively impaired resident. - The Annual Minimum Data Set (MDS) dated 10/21/2015 revealed Resident #14 required supervision only for toileting, bed mobility, transfers, and locomotion on and off unit, and was occasionally incontinent of bladder. The Quarterly MDS dated 1/12/2016 revealed the same information, except the resident required extensive assistance of one person for toileting. Observation of resident on 2/10/2016 revealed the resident sitting in a chair in a facility common room, with his/her walker nearby. He/She stood up from the chair, without any assistance, and used the walker to ambulate down the hall. Gait was steady and appropriate. Record review revealed Care Plan dated 2/3/16, noting the resident was independent with toileting,	F 278		

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F 278	Continued From page 6 but staff may need to provide assistance changing his/her brief after occasional incontinence episode. Interview on 2/10/2016 at 8:30 A.M., Licensed Staff H stated the resident is incontinent "occasionally," but incontinence or assistance has not increased, and staff will help change her pad due to small leakage. The resident will report this incontinence to nurses and ask for assistance. Staff provides pericare (cleaning of genitals and anal area). "He/She could try to do it, but probably couldn't do it well enough on her own." When asked if his/her incontinence has increased recently, Licensed Staff H claimed, "That is the way (he/she) has always been." Interview on 2/10/2016 at 11:16 A.M., the resident stated he/she feels the urge to void, but occasionally doesn't make it to the bathroom in time and will "go a little bit." When this happens, he/she wants his/her pad changed, and staff will assist with changing the pad and helping him/her with skin care. Interview on 2/10/2016 at 3:35 P.M., Direct Care Staff O claimed this resident uses the bathroom independently, but is incontinent occasionally while walking to the bathroom. Direct Care Staff O claimed he/she documents this assistance at the end of each shift. When asked if he/she provides extensive assistance to this resident, Direct Care Staff O said "No." When asked what care he/she provides to this resident after incontinence, he/she claimed to provide pericare. In an interview on 2/10/2016 at 4:05 P.M., Administrative Staff E claimed MDS scores are determined based on the information charted by staff, as they document how often they provide	F 278		

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F 278	Continued From page 7 care and how extensive they give assistance. This staff stated he/she was not directly involved in this resident's daily cares, but is aware the resident toilets independently and is occasionally incontinent if unable to reach a bathroom quickly. Administrative Staff E stated previous MDS scores may have been inaccurate because staff is now being educated about the definitions of terms. For example, staff may not understand providing pericare to a resident after incontinence qualifies as "extensive assist," which should then be charted accordingly. Some staff has been educated on proper definitions of care, so MDS scores have increased, although the residents' conditions have not changed. The facility failed to provide an accurate assessment for toileting for this resident.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

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F 279	Continued From page 8 under §483.10(b)(4). This Requirement is not met as evidenced by: The facility identified a census of 82 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to develop a care plan for 1 (#54) resident for a new skin abrasion. Findings included: - The Physician's Order Sheet dated 1/21/16 for resident #54 noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The Quarterly Minimum Data Set (MDS) dated 1/27/16 noted a Brief Interview for Mental Status (BIMS) of 3 (indicated severely impaired cognition), required extensive assist with bed mobility, transfers, walking in corridor, dressing, and eating. He/she was totally dependent on staff for locomotion on and off of unit, toileting, and personal hygiene. He/she received scheduled pain medications and showed non-verbal signs of pain 3 to 4 days of 5. The Care Area Assessments (CAA) dated 8/11/15 noted the resident continued to declined in cognition. He/she needed cueing and reminding for everything. The Activities of Daily Living (ADL) CAA did not trigger. The care plan dated 1/28/16 noted staff was to speak slowly and clearly to the resident, and give the resident ample time to respond.	F 279		

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F 279	Continued From page 9 Review of the nurses' notes and Treatment Administration Record for February 2016 lacked evidence of any skin issue. Observation on 02/09/16 at 10:02 A.M. there was scabbed abrasion on the resident's right lower leg. Interview on 02/10/16 at 4:17 P.M. direct care staff P stated he/she reported any skin changes to the nurse. Interview on 02/11/16 at 10:00 A.M. licensed nursing staff I stated he/she was unaware of the abrasion. He/she stated direct care staff was expected to pass on any new skin issues. Interview on 02/11/16 at 11:40 A.M. administrative nursing staff D stated he/she expected the care plans to be developed as needed. The clinical record lacked documentation of abrasion on the right shin. The facility's undated policy "Care Plans" were developed for each resident using the results of the comprehensive assessment. The facility failed to develop a care plan about skin issues for this cognitively impaired resident with an abrasion.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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F 280	Continued From page 10 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility had a census of 82 residents with 13 selected for sample. Based on observation, interview, and record review the facility failed review and revise one sampled resident's care plan related to non-pressure related skin issues (#30). Findings included: - The Annual MDS (minimum data set) assessment for resident #30 dated 8/10/15 revealed the resident had severe cognitive impairment with daily behavioral symptoms of physical and verbal behaviors directed towards others. The assessment also indicated the resident rejected cares daily. The resident was dependent on 2 persons for bed mobility, transfers, dressing, and toilet use. He/she was dependent on 1 person for eating and personal hygiene. The assessment revealed the resident had no unhealed pressure ulcers or skin issues.	F 280		

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F 280	Continued From page 11 The 8/12/15 ADL CAA (care area assessment) stated the resident required total assistance with all ADLs and he/she stayed in his/her room most of the time to decrease stimuli, as that seemed to trigger disruptive behaviors. The 1/25/16 quarterly MDS revealed the resident had a BIMS (brief interview for mental status) score of 3 which indicated severe cognitive impairment and remained unchanged from the previous assessment. The resident's 4/28/14 nursing care plan directed staff to use a calm approach with 1 to 2 staff assistance with ADLs. A revision to the care plan on 12/5/15 revealed the resident yelled out and hit the arms of his/her chair. The care plan directed staff if the resident could not be redirected, to close the door to his/her room part way to protect his/her dignity and rights of others, and attempt at a later time. The care plan lacked interventions to protect the resident's skin from injury and lacked revision after the resident sustained skin tears on 12/29/15 and 1/29/16. Review of the resident's skin assessment on 12/29/15 revealed the resident had a skin tear on the right forearm that measured 4 cm (centimeters) by 1.5 cm with sanguineous (bloody) drainage. According to the documentation, staff discovered the skin tear on 12/19/15, applied steri strips (adhesive strips used to close a wound), and applied a telfa (non-stick) dressing to the wound with continued follow-up of the wound every Wednesday and Saturday until healed. Subsequent skin assessments revealed the wound resolved on 1/13/16. A nurse's note dated 1/29/16 revealed the	F 280		

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F 280	Continued From page 12 resident sustained a skin tear to the right forearm when staff assisted with getting him/her ready for bed. The nurse documented he/she cleansed the area, applied steri strips, a telfa (non-stick) dressing, and wrapped the resident's forearm with a gauze dressing. According to the note, the resident was resistant and combative during cares and the nurse reinforced to staff to leave the resident alone until he/she calmed down when the resident became combative in order to prevent injuries. During an observation on 2/11/16 at 8:24 a.m., the resident sat in his/her room in a chair with the skin tear to the right arm open to air. Licensed nurse F stated the resident just showered and staff cleansed the wound during the shower. The resident had a large skin tear on his/her right forearm, anterior to the elbow, that was approximately 10 cm in length. The skin tear curved at the elbow region and was pink with slight swelling. The wound remained closed with steri strips intact. Nurse F covered the area with a telfa pad and secured the dressing with gauze. During an interview on 2/10/16 at 11:56 a.m., licensed nurse H stated the nurses changed the resident's dressing daily. Interview on 2/11/16 at 8:24 a.m., licensed nurse F stated when a resident received a skin tear, the nurse should initially measure and document the size of the wound and initiate follow up assessments twice a week until the wound heals. Nurse F further stated the resident received daily dressing changes. An interview on 2/11/16 at 12:57 p.m., administrative nurse D expected licensed nurses to measure and document the skin tear and to	F 280		

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F 280	Continued From page 13 initiate follow-up assessments twice weekly until the skin tear healed. Nurse B also verified the resident's care plan should be revised with interventions to treat the skin tear and prevent further skin tears. Nurse B confirmed the resident had a history of skin tears and had fragile skin. The facility's 7/20/15 wound care policy for skin tears directed staff to initiate care plan interventions regarding the skin tear. The facility failed to revise the resident's nursing care plan with interventions to treat and prevent skin tears he/she sustained on 12/29/15 and 1/29/16.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: The facility had a census of 82 residents with 13 selected for sample. Based on observation, interview, and record review the facility failed to assess and monitor non-pressure related skin issues for 2 of 3 residents sampled for skin conditions (#30 and #67). Findings included: - The Annual MDS (minimum data set) assessment for resident #30 dated 8/10/15	F 309		

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(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
F 309	Continued From page 14 revealed the resident had severe cognitive impairment with daily behavioral symptoms of physical and verbal behaviors directed towards others. The assessment also indicated that the resident rejected cares daily. The resident was dependent on 2 persons for bed mobility, transfers, dressing, and toilet use. He/she was dependent on 1 person for eating and personal hygiene. The assessment revealed the resident had no unhealed pressure ulcers or skin issues. The ADL (activities of daily living) CAA (care area assessment) dated 8/12/15 stated the resident required total assistance with all ADLs and he/she stayed in his/her room most of the time to decrease stimuli, as that seemed to trigger disruptive behaviors. The Quarterly MDS dated 1/25/16 revealed the resident had a BIMS (brief interview for mental status) score of 3 which indicated severe cognitive impairment and remained unchanged from the previous assessment. The nursing care plan dated 4/28/14 directed staff to use a calm approach with 1 to 2 staff assistance with ADLs. A revision to the care plan on 12/5/15 revealed the resident yelled out and hit the arms of his/her chair. The care plan directed staff that if the resident could not be redirected, to close the door to his/her room part way to protect his/her dignity and rights of others, and attempt at a later time. The care plan lacked interventions to protect the resident's skin form injury and lacked revision after the resident sustained skin tears on 12/29/15 and 1/29/16. Review of the skin assessment on 12/29/15 revealed the resident had a skin tear on the right forearm that measured 4 cm (centimeters) by 1.5	F 309		

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F 309	Continued From page 15 cm with sanguineous (bloody) drainage. According to the documentation, staff discovered the skin tear on 12/19/15, applied steri strips (adhesive strips used to close a wound), and applied a telfa (non-stick) dressing to the wound with continued follow-up of the wound every Wednesday and Saturday until healed. Subsequent skin assessments revealed the wound resolved on 1/13/16. A nurse's note dated 1/29/16 revealed the resident sustained a skin tear to the right forearm when staff assisted with getting him/her ready for bed. The nurse documented he/she cleansed the area, applied steri strips, a telfa (non-stick) dressing, and wrapped the resident's forearm with a gauze dressing. According to the note, the resident was resistant and combative during cares and the nurse reinforced to staff to leave the resident alone until he/she calmed down when the resident became combative in order to prevent injuries. Review of the clinical record revealed no documentation of the size or appearance of the skin tear he/she received on 1/29/16. The clinical record also lacked any further follow up assessments of the skin tear. Review of the resident's TAR (treatment administration record) failed to include daily dressing changes for the skin tear sustained on 1/29/16. The facility's undated standing orders directed staff to use normal saline to cleanse skin tears, apply steri strips if needed, and cover with a dry dressing. During an observation on 2/9/16 at 1:54 p.m. the resident sat in his/her chair napping and had a gauze dressing on his/her right forearm.	F 309		

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F 309	Continued From page 16 During an observation on 2/11/16 at 8:24 a.m. the resident sat in his/her room in a chair with the skin tear to the right arm open to air. Licensed nurse F stated the resident just showered and staff cleansed the wound during the shower. The resident had a large skin tear on his/her right forearm, anterior to the elbow, that was approximately 10 cm in length. The skin tear curved at the elbow region and was pink with slight swelling. The wound remained closed with steri strips intact. Nurse F covered the area with a telfa pad and secured the dressing with gauze. During an interview on 2/10/16 at 11:56 a.m., licensed nurse H stated the nurses changed the resident's dressing daily. During an interview on 2/1016 at 4:09 p.m. direct care staff O stated the resident had a history of getting skin tears when he/she was combative. Interview on 2/11/16 at 8:24 a.m., licensed nurse F stated when a resident received a skin tear, the nurse should initially measure and document the size of the wound and initiate follow up assessments twice a week until the wound heals. Nurse C further stated the resident received daily dressing changes and the treatment should be on the TAR, so the nurse checks the wound daily. Nurse F confirmed the TAR did not include a dressing change for the skin tear. An interview on 2/11/16 at 12:57 p.m. administrative nurse D expected licensed nurses to measure and document the skin tear and to initiate follow-up assessments twice weekly until the skin tear healed. Nurse D also verified the dressing changes should be listed on the TAR as well as the resident's care plan. Nurse D	F 309		

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F 309	Continued From page 17 confirmed the resident had a history of skin tears and had fragile skin. The facility's Wound Care policy for skin tears, dated July 2015, directed staff to investigate and document the cause of a skin tear, cleanse the area with normal saline or sterile water, apply steri strips if needed, and dressings may be used if needed. The policy also stated follow up documentation will occur until resolved or healed with follow up entered in the electronic medical record scheduler system for 2 times weekly and added to the TAR. The policy further directed staff to initiate care plan interventions regarding the skin tear. The facility failed to thoroughly assess and monitor this resident's skin tear sustained on 1/29/16. This resident had physical behaviors, fragile skin, and a history of skin tears. - The 12/16/2016 Quarterly Minimum Data Set (MDS) revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. The resident had signs of delirium including altered level of consciousness and psychomotor retardation that were present but fluctuating. Behavioral symptoms not directed towards others occurred daily. The resident was totally dependent on assistance of one person for dressing and bathing. The October 2015 Physician's Order Sheet (POS) listed diagnoses of Alzheimer's Disease, unspecified; major depressive disorder, single episode, unspecified; bipolar disorder, unspecified; unspecified dementia with behavioral disturbance; and unspecified mood disorder.	F 309		

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F 309	Continued From page 18 Record review revealed a Skin Care Plan dated 11/26/2015, instructing staff to assess skin weekly and document on the Treatment Administration Record (TAR). A Skin Care Plan dated 12/10/2015 revealed the resident should be dressed in long sleeves at all times to prevent scratching, and bandages are ineffective because he/she pulls them off and continues to pick at his/her wounds. Record review of the February 2016 TAR revealed instructions for staff to "Check skin 1xweek to ensure that there is no breakdown." The TAR revealed staff did not identify any specific skin issues. The "Skin/Feet Conditions" section of the resident's Nursing Assessments chart revealed a lack of details, locations, or measurements of wounds. The most recent entry was on 2/9/16, which revealed, "Location: forearms/wrists," "Color: thin scabs present," "Healing Process: no change, resident frequently picks at areas which impedes healing." The Nursing Assessment lacked the number of wounds present, specific locations, sizes, or color of surrounding tissue. The previous skin assessment was from 12/31/2015, which noted an abrasion/laceration to back of head. The skin assessment lacked evidence the facility documented any wounds on resident's forearms/wrists. In an interview on 2/10/2016 at 8:33 A.M., Licensed Staff H claimed this resident is assessed for a targeted behavior of picking at his/her skin. Interventions include providing him/her with rubber balls to squeeze, giving	F 309		

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F 309	Continued From page 19 him/her a beverage to hold, and always ensure he/she is wearing long sleeves. In an interview on 2/11/2016 at 7:41 A.M., Licensed Staff J stated full skin assessments are performed weekly, and are charted in the TAR and in the "Skin/Feet Conditions" section of the Nursing Assessment, but he/she stated staff assesses the resident's hands and wrists every day. He/She said, "We can't stop him/her from picking," so staff assesses the wounds to determine if they are infected or if they "get too deep." When asked how staff knows if wounds are healing properly, he/she claimed staff works with the same residents on a regular basis so they know if they are getting larger or smaller, or if they are new. Additional skin assessments are performed by direct care staff when they provide baths or other daily cares, and those staff members report abnormal findings to the licensed nurse. In an interview on 2/11/2016 at 10:10 A.M., Direct Care Staff Q claimed he/she performs skin assessments on this resident when bathing or performing daily cares, and reports new or open wounds to the licensed nurse on duty. However, he/she said, " It ' s hard to keep track of (his/her) wounds, " because they are often present, but he/she stated, "You can tell an old one from a fresh new one, the old ones have a scab and it's more dry, the newer ones are more wet and don't have a scab." He/She claimed to have not seen a new wound in " about a week," which he/she reported to the nurse that day. Observation on 2/8/16 at 3:35 P.M. revealed the resident had two scabs on his/her left hand and three scabs on his/her right hand.	F 309		

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F 309	Continued From page 20 Observation on 2/10/2016 at 8:06 A.M. revealed the resident sitting in his/her room, in his/her wheelchair, wearing long sleeves up to his/her wrists. Observation on 2/11/2016 at 10:13 A.M. revealed the resident sitting by the nurse ' s station, in his/her wheelchair, wearing long sleeves up to his wrists. Record review revealed the document titled "Apostolic Christian Home Wound Care and Pressure Ulcers," which included directives to cleanse wounds and apply steri strips if needed, and dressings may be used at the nurse/physician discretion. However, the policy states "follow up documentation will occur until resolved or healed," follow up will be scheduled " 2x/week," and "a care plan will be initiated regarding the skin tear." The nursing assessments lacked specific wound care documentation, including appearance of new wounds, specific locations, measurements, color of tissue, or any open areas or drainage. The care plan failed to follow the facility ' s policy on skin care, which would require assessments twice a week and documentation on each wound until resolved. The facility failed to provide a complete skin wound assessment for this resident.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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F 329	Continued From page 21 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 82 residents. The sample was 13 residents with 5 residents sampled for medication reviews. Based on record review, and interview, the facility failed to monitor the effectiveness of medications for one (#54) resident. Findings included: - The Physician's Order Sheet dated 1/21/16 for resident #54 noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The physician's orders included an order with a start date of 8/15/12 for Glimepride 1 milligram	F 329		

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F 329	Continued From page 22 (mg) by mouth daily (a medication to control the blood sugar). The Quarterly Minimum Data Set (MDS) dated 1/27/16 noted a Brief Interview for Mental Status (BIMS) of 3 (indicated severely impaired cognition), required extensive assist with bed mobility, transfers, walking in corridor, dressing, and eating. He/she was totally dependent on staff for locomotion on and off of unit, toileting, and personal hygiene. The Annual MDS dated 8/11/15 noted a BIMS of 4 (indicated severely impaired cognition), required extensive assistance with bed mobility, transfers, walking in room, dressing and personal hygiene and limited assistance with locomotion on and off of the unit. He/she was totally dependent of staff for toileting and bathing. Medications were used to give the resident a better quality of life and dignity. The Activities of Daily Living (ADL) CAA did not trigger. The care plan dated 1/28/16 noted staff was to speak slowly and clearly to the resident, and give the resident ample time to respond. Review of the Medication Administration Records (MARs) from November 2015 through February 11, 2016 documented the resident received Glimepride every day. The undated physician standing orders revealed residents who had diabetes mellitus were to have a HgbA1c (a lab test that monitors the resident's blood sugar) every 3 months. The clinical record lacked evidence the facility obtained this lab test.	F 329		

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F 329	Continued From page 23 Observation on 02/09/16 at 2:15 P.M. the resident reclined in a chair with eyes closed. Interview on 02/10/16 at 4:19 P.M. direct care staff H stated the resident was monitored for lethargy and withdrawal from activities. Interview on 02/11/16 at 10:04 A.M. licensed nursing staff I stated the assistant director of nursing (ADON) was responsible to ensure the ordered lab results were obtained and recorded. Interview on 02/11/2016 at 11:42 A.M. administrative nursing staff D stated it was the director of nursing (DON) and his/her ADON's responsibility to ensure lab is done as ordered. He/she confirmed the lack of evidence the facility obtained this lab test. The facility failed to provide a medication monitoring policy. The facility failed to monitor the effectiveness of a medication for this cognitively impaired resident.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This Requirement is not met as evidenced by:	F 428		

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F 428	Continued From page 24 The facility identified a census of 82 residents. The sample was 13 residents with 5 residents sampled for medication reviews. Based on record review, and interview, the facility's pharmacy consultant failed to recommend appropriate testing in order to monitor the effectiveness of medications for one (#54) resident. Findings included: - The Physician's Order Sheet dated 1/21/16 for resident #54 noted diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin). The physician's orders included an order with a start date of 8/15/12 for Glimepride 1 milligram (mg) by mouth daily (a medication to control the blood sugar). The Quarterly Minimum Data Set (MDS) dated 1/27/16 noted a Brief Interview for Mental Status (BIMS) of 3 (indicated severely impaired cognition), required extensive assist with bed mobility, transfers, walking in corridor, dressing, and eating. He/she was totally dependent on staff for locomotion on and off of unit, toileting, and personal hygiene. The Annual MDS dated 8/11/15 noted a BIMS of 4 (indicated severely impaired cognition), required extensive assistance with bed mobility, transfers, walking in room, dressing and personal hygiene and limited assistance with locomotion on and off of the unit. He/she was totally dependent of staff for toileting and bathing. Medications were used to give the resident a better quality of life and dignity. The Activities of Daily Living (ADL) CAA	F 428		

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F 428	Continued From page 25 did not trigger. The care plan dated 1/28/16 noted staff was to speak slowly and clearly to the resident, and give the resident ample time to respond. Review of the Medication Administration Records (MARs) from November 2015 through February 11, 2016 documented the resident received Glimepride every day. The undated physician standing orders revealed residents who had diabetes mellitus were to have a HgbA1c (a lab test that monitors the resident's blood sugar) every 3 months. The clinical record lacked evidence the facility obtained this lab test. Pharmacist medication reviews dated 12/11/14, 1/6/15, 2/2/15, 3/2/15, 4/7/15, 5/1/15, 6/2/15, 7/6/15, 8/4/15, 9/1/15, 10/5/15, 11/3/15, 12/1/15, 1/4/16, and 2/1/16 failed to recommend obtaining this lab test. Observation on 02/09/16 at 2:15 P.M. the resident reclined in a chair with eyes closed. Interview on 02/10/16 at 4:19 P.M. direct care staff H stated the resident was monitored for lethargy and withdrawal from activities. Interview on 02/11/16 at 10:04 A.M. licensed nursing staff I stated the assistant director of nursing (ADON) was responsible to ensure the ordered lab results were obtained and recorded. Interview on 02/11/16 at 11:42 A.M. administrative nursing staff D stated it was the director of nursing (DON) and his/her ADON's responsibility	F 428		

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F 428	Continued From page 26 to ensure lab is done as ordered. He/she confirmed the lack of evidence the facility obtained this lab test. Interview on 02/15/16 at 10:37 A.M. pharmacy consultant KK stated he/she reviewed the resident's clinical record for lab results, and would recommend any lab needed. The facility failed to provide a medication monitoring policy. The facility failed to monitor the effectiveness of a medication for this cognitively impaired resident.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		

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APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT STREET SABETHA, KS 66534

(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
F 441	Continued From page 27 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility identified a census of 82 residents. Based on observation, record review and staff interview, the facility failed to utilize precautions to minimize transmission of infection within the facility, and failed to establish an Infection Prevention and Control Program that performed surveillance and investigation to prevention the onset and the spread of infection. Findings included: -Observation on 02/10/2016 at 10:30 AM housekeeping staff Y cleaned a resident's bathroom revealed he/she sprayed a yellow solution on the sink. There was a faded hand-written mark on the bottle that he/she claimed was LD-64 disinfectant. He/she squeezed a solution from a bottle labeled Meyer Tobo into the toilet bowl. He/she brushed inside the bowl, starting at the bottom, and brushed upwards and outwards to the rims. He/she then brushed under the toilet seat with the same brush. He/she immediately brushed off the disinfectant.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	175376		02/15/2016

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F 441	Continued From page 28 Observation on 02/11/2016 at 7:27 AM housekeeping staff Z cleaned a resident's bathroom revealed he/she squeezed a solution from a bottle labeled Meyer Tobo into the toilet bowl. He/she sprayed a yellow solution marked with Meyer LD-64 onto the surfaces of the toilet, wiped down the surfaces with a rag, and brushed the toilet bowel from rims toward the bowl inside. He/she immediately brushed off the disinfectant. Interview on 02/11/2016 at 7:38 AM housekeeping staff Y revealed that she cleaned the inside of the bowl first then to the rims unless the toilet bowel was visibly soiled. He/she was not certain about the contact time of the solutions. Interview on 02/11/2016 at 8:15 A.M. housekeeping staff X revealed housekeeping staff were to spray the surfaces of the toilet with Meyer LD-64 solution, let it stand for approximately 10 minutes, and then wipe it off with a clean rag. Then to pour the Tobo into the toilet bowel, wait for approximately 10 minutes before brushing, and clean the outside first going inwards. Interview on 02/11/2016 at 11:08 AM housekeeping staff Z revealed he/she was aware of the LD-64 and the Tobo were supposed to be left on the surface for at least 10 minutes. Review of the label on Meyer LD-64 one step disinfection detergent and deodorant used by the housekeeping staff revealed the spray should remain on the surface for a minimum 10 minutes, and then it was to be rinsed or allowed to air dry. Review of the label on Meyer Tobo antimicrobial cleaner used by the housekeeping staff should be allowed to remain 10 minutes, and then brushed	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 29 with clean water. The solution was to be used inside of the bowl only. Review of the undated policy of housekeeping procedure A revealed staff were to spray LD-64 solution outside toilet tank and toilet bowl, then clean inside of the toilet bowl and flush. It did not specify the contact time or mention the Meyer Tobo solution. The facility failed to effectively clean the resident bathrooms to prevent the spread of infection. - Review of the facility ' s clinical records documented residents who received antibiotics and for what infection, but failed to track a pattern throughout the facility. Interview on 02/11/2016 at 9:51 AM administrative nursing staff G revealed the nursing staff documented the antibiotic use for each resident, and the corresponding diagnoses. The facility failed to establish an Infection Control Program which investigated, controlled and prevented infections within the facility.	F 441		