

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

PRINTED: 06/15/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>175353</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/15/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ARMA OPERATOR, LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>605 E MELVIN STREET PO BOX 789</b> <b>ARMA, KS 66712</b>		
(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	F 000			
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 37 residents. Based on observation, interview and record review, the facility failed to provide wheelchair securement during transport for 1 (#01) of 3 sampled residents, who utilized the facility van for transports, to prevent accidents during transports.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The medical record evidenced the facility re-admitted resident #01 on 5/25/16. Diagnoses listed by the physician included, chronic hepatitis (inflammation of the liver), necrotizing fasciitis (inflammation of the membrane covering the muscles) and congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid).</li> </ul> <p>The 6/1/16 admission MDS (minimum data set), identified the resident with cognition intact and the</p>	F 323			

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 323	<p>Continued From page 1</p> <p>need for assistance with transfers. The resident did not walk during the assessment observation period.</p> <p>The care plan, dated 6/6/16 included, the resident was at risk for falls related to deconditioning, and gait/balance problems. Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces.</p> <p>On 6/4/16 at 2:30 P.M., progress notes revealed the facility sent the resident to the ER (emergency room) per ambulance for a complaint of chest pain and shortness of breath. Following assessments the hospital called and reported no acute findings and requested the facility van return to pick the resident up.</p> <p>Per interview on 6/7/16 at 8:20 A.M., by administrative staff A and with his/her review of the written statement by direct care staff C, dated Saturday, 6/4/16 at approximately 4:30 P.M., revealed the following. Direct care staff C traveled to the hospital and loaded the resident into the facility van in his/her wheelchair. The report confirmed direct care staff C failed to properly strap the wheelchair down in the van and failed to use the seat belts/harness on the resident, in the van, before transport. When the van turned to leave the hospital area the resident and his/her wheelchair fell over. Direct care staff C documented he/she got distracted talking and forgot to strap the resident in properly before moving the van. The statement by direct care staff C reported the fall in the van, to the charge nurse upon arrival back at the facility. Licensed staff B examined the resident for injuries. The staff administered the resident PRN (as needed)</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>pain medication and anti-anxiety medications. The assessment revealed a skin tear to the resident's left antecubital area, which measured 5 cm (centimeters) by 0.1 cm. The resident's left 3rd toenail was missing and bleeding, and the resident also sustained an abrasion on the bottom of the foot (no measurement documented). Nurse B cleaned the wounds and applied an antibiotic cream, dressed the areas with non-adherent dressings and covered the areas with kerlex. Nurse B placed the resident on fall follow-up with neurological checks due to the fall to monitor.</p> <p>Progress notes, dated Monday, 6/6/16 included, the resident complained of neck pain, this morning, and stated he/she fell Saturday and on his/her way from the ER. He/she had an accident and hurt his/her neck. Staff notified the physician, who ordered to x-ray the resident's neck, and updated pain medication orders, to give hydrocodone (pain pill) every 4 hours prn.</p> <p>The resident received multiple x-rays on 6/6/16. The following conclusions were documented, no acute fracture or dislocation.</p> <p>On 6/7/16 at 9:30 A.M., administrative staff A acknowledged direct care staff C was not the routine van transportation driver. He/she also reported the facility failed to provide staff C with any formal facility van training or check off, before the transport/incident.</p> <p>Observation, on 6/7/16 at 9:10 A.M., revealed the routine facility transportation staff member D, placed the resident in the facility van in the wheelchair. He/she anchored the wheelchair with the resident facing forward in the van, with floor</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>straps on each side of the chair and with the brakes on. Routine van driver D, also secured the resident with the waist and shoulder harness.</p> <p>The facility van transportation policy, dated 4/2016 included, drivers skill validations will be completed with transportation person before their initial assignment of transporting residents with the communities' vehicle and annually. Required driver skills validations are:</p> <ol style="list-style-type: none"> <li>Boarding the wheelchair bound resident into the vehicle.</li> <li>Wheelchair and resident securement.</li> <li>Removing the wheelchair and resident from vehicle.</li> <li>Operating the lifts manual back up system.</li> </ol> <p>On 6/6/16, licensed nursing staff E completed a performance correction notice for direct care staff C/substitute van driver. The facility also provided staff C with training and completed a checklist for securing wheelchairs and facility van operation guidelines, two days after the incident.</p> <p>The facility failed to ensure the resident received a safe facility van transport by an adequately trained staff member. The van driver failed to secure the resident and his/her wheelchair, with the built in assistive devices when placed in the van for transport. The resident fell from the wheelchair, when the chair fell over in the moving van. The resident received abrasions, bruises, skin tears and the loss of a toenail.</p>	F 323			