

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 250 SS=D	<p>The following citations represent the findings of partial extended complaint investigation #101865.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 83 residents. The sample included 3 residents. Based on observation, interview and record review, the facility failed to provide medically related social services to meet 1 of 3 residents' (#1) needs regarding the resident's desires for dental services and leaving the facility.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The June 2016 Physician Order Sheet (POS) for resident #1 included diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder), intellectual functioning disability (significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills), COPD (Chronic Obstructive Pulmonary Disease - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and deaf mutism (unable to hear or speak).</li> </ul>	F 250		
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.

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 250	<p>Continued From page 1</p> <p>The annual Minimum Data Set (MDS) dated 1/28/16, recorded the resident had a level II Preadmission Screening and Resident Review (PASRR: a federal requirement to help ensure that individuals with mental illness and intellectual/developmental disability, were not inappropriately placed in nursing homes for long term care) for serious mental illness and intellectual disability. The resident had highly impaired hearing, did not have speech, and he/she had an intact short and long term memory. The resident exhibited delusions and behaviors toward self. The resident had modified independence with decision making. He/she did not exhibit wandering behaviors.</p> <p>The significant change MDS dated 3/31/16 revealed the resident had a level II PASRR for serious mental illness and intellectual disability. The resident had highly impaired hearing and did not have speech. The resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. He/she did not exhibit wandering behaviors.</p> <p>The Care Area Assessment (CAA) dated 3/31/16 revealed the resident was deaf and non-speaking. The resident had diagnoses of depressive disorder, schizophrenia, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and intellectual disability.</p> <p>The comprehensive care plan dated 11/10/14 documented the resident was not planned to discharge from the facility.</p> <p>The care plan dated 4/6/16, noted the resident had delusions (untrue persistent belief or perception held by a person although evidence</p>	F 250			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 250	<p>Continued From page 2</p> <p>shows it was untrue) due to the disease, staff were not to redirect him/her as the interventions could worsen the behaviors. The care plan lacked interventions for the resident's unsafe wandering behaviors.</p> <p>A review of PASRR determination letter from Kansas Department for Aging and Disability Services, dated 4/4/16, noted the resident benefited from staff ' s interventions to help decrease his/her risk of wandering. The facility documented a group home or assisted living facility was in the resident's care plan for discharge, so that he/she had a goal to transition back into the community.</p> <p>A review of the facility ' s incident report, dated 1/7/16 (incorrect date), recorded the resident left the facility on 3/9/16 at 6:45 PM and rode a bike to the bus station to go to a metro city without staff's awareness and the facility did not notify the law enforcement until 10:00 PM. The report also noted the resident went to the metro city for dental services.</p> <p>A review of the incident report from the local police department, dated 3/9/16, recorded the facility contacted the law enforcement at 10:45 PM and reported that the resident was missing since 2 PM on 3/9/16. The facility staff was not sure if the resident rode a bike or what he/she wore that day. The report noted the facility staff did not express concern of the resident, and he/she needed the police report for the corporate use. The report noted the metro city police contacted the facility on 3/11/16 at 12:57 PM when they found the resident.</p> <p>A review of social worker note dated 3/11/16, noted the resident appeared to understand the</p>	F 250			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 250	<p>Continued From page 3 information provided.</p> <p>A review of the Behavior Risk Assessment, dated 3/31/16, noted the resident paced and aimlessly wandered once or twice a week.</p> <p>A review of the Resident Sign in/out Record, dated 6/16/16, noted the resident signed out at 8:50 AM.</p> <p>A review of the Staff Every-2-hour Check Log, dated 6/16/16, noted the staff marked the resident was in A hall at 10am and in dining room at 12 noon.</p> <p>A review of social worker note dated 3/30/16 and 6/22/16, noted the contents were nearly identical: the resident did not report any plans to discharge from the facility in the near future and clinical staff did not anticipate his/her departure.</p> <p>On 6/3/16 at approximately noon, state employee S reported the resident walked in to downtown state office building and looked for housing and food. The state employee reported to the state agency.</p> <p>On 6/16/16 at 11:25 AM, state employee S reported the resident walked in to a downtown state office building and looked for food. The state employee reported to the state agency.</p> <p>On 6/16/16 at 11:37 AM, surveyor Q observed the resident in a black T shirt and orange pants in a state office building. The local public digital temperature display recorded a temperature of 81 degrees Fahrenheit. According to wunderground.com, at 11:53 A.M. the temperature was 80.1 degrees Fahrenheit outside with a heat index of 82.9 and a heat</p>	F 250			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>	
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE  <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 250	<p>Continued From page 4</p> <p>advisory in effect. The resident did not have a paper or pen, and he/she did not have any water. During the written interview, the resident was asked if he/she was thirsty, and he/she shook his/her head yes. He/she was provided a large Solo cup of ice water which he consumed within approximately 2 minutes. A second cup was provided and mostly consumed within a few additional minutes. The resident was unable to hear and unable to communicate verbally, but used a pen and paper for minimal communication.</p> <p>On 6/16/16 at 11:49 AM, surveyor Q contacted the facility administrative staff A. Staff A stated he/she was not aware of the resident's current location and neither did he/she know when the resident was expected to return.</p> <p>On 6/16/16 at 4:00 PM, social worker staff B stated he used flash cards to assess the deaf resident with BIMS scores and other MDS assessments. However, at this time, staff B could not locate the cards when asked to see them.</p> <p>On 6/21/16 at 11:23 PM, social worker staff B stated he/she did not use flash cards to assess the resident's BIMS scores.</p> <p>On 6/21/16 at 10:14 AM, social worker staff B stated he/she provided one on one conversation when the resident requested. Staff B reported the PASRR documented the resident had a behavior of wandering was inaccurate because the resident did not wander. He/she added he/she just became aware the resident sought food, housing and assistance in the community on June 3, 2016. Staff B also confirmed there was not a discharge care plan for the resident.</p>	F 250		

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 250	Continued From page 5 The facility failed to provide medically related social services to address the needs of discharge, safety when outside of the facility and failed to follow the PASRR recommendations for the resident, who was deaf and mentally ill.	F 250		
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.  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 identified a census of 83 residents. The sample included 3 residents. Based on observation, interview and record review, the facility failed to revise care plan to reflect the resident's status changes identified on the PASSR (Pre Admission Screening Resident Review), failed to revise the care plan after a resident left the facility unattended for two days and failed to revise the care plan to include	F 280		

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 280	<p>Continued From page 6</p> <p>specific interventions for the resident when out of the facility during inclement weather for 1 of the 3 residents (#1).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The June 2016 Physician Order Sheet (POS) for resident #1 included diagnoses of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder), intellectual functioning disability (significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills), Chronic Obstructive Pulmonary Disease ( COPD: progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and deaf mutism (unable to hear or speak).</li> </ul> <p>The annual Minimum Data Set (MDS) dated 1/28/16 recorded the resident had a level II Preadmission Screening and Resident Review (PASRR: a federal requirement to help ensure that individual with mental illness and intellectual/developmental disability, were not inappropriately placed in nursing homes for long term care) for serious mental illness and intellectual disability. The resident had highly impaired hearing and did not have speech, and he/she had an intact short and long term memory. The resident exhibited delusions and behaviors toward self. The resident had modified independence with decision making. He/she did not exhibit wandering behaviors.</p> <p>The significant change MDS dated 3/31/16 revealed the resident had a level II Preadmission</p>	F 280			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 280	<p>Continued From page 7</p> <p>Screening and Resident Review (PASRR) for serious mental illness and intellectual disability. The resident had highly impaired hearing and did not have speech. The resident had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. He/she did not exhibit wandering behaviors.</p> <p>The Care Area Assessments (CAAs) dated 3/31/16 revealed the resident was deaf and non-speaking. The resident had diagnoses of depressive disorder, schizophrenia, anxiety and intellectual disability. The resident was deaf and non-speaking. The resident communicated through writing and gestures and answered best to yes/no questions, but was able to make needs known.</p> <p>The care plan dated 4/6/16, noted the resident had delusions due to the disease, staff were not to redirect him/her as the interventions could worsen the behaviors; the resident was not to discharge from the facility. The care plan lacked revision of the interventions for the resident ' s safety awareness and behaviors of leaving the facility without notifying the staff, and lacked a revision regarding discharge planning.</p> <p>A review of PASRR determination letter from Kansas Department for Aging and Disability Services (KDADS), dated 4/4/16, noted the resident benefited from staff's interventions to help decrease risk of wandering; the letter documented a group home or assisted living facility in the resident's care plan for discharge, so that he/she had a goal to transition back into the community.</p> <p>A review of the facility's incident report, dated 1/7/16 (incorrect date), recorded the resident left</p>	F 280			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 280	<p>Continued From page 8</p> <p>the facility on 3/9/16 at 6:45 PM and rode a bike to the bus station to go to a metro city without staff's knowledge and the facility did not notify the law enforcement until 10:00 PM. The metro city police department located the resident on 3/11/16 at 12:57 PM. The report also noted the resident went to the metro city for dental services.</p> <p>A review of the incident report from the local police department, dated 3/9/16, recorded the facility contacted the law enforcement at 10:45 PM and reported that the resident was missing since 2 PM on 3/9/16. The facility staff was not sure if the resident rode a bike or what he/she wore that day. The report noted the facility staff did not express concern of the resident, and he/she needed the police report for the corporate use.</p> <p>A review of the Behavior Risk Assessment, dated 3/31/16, noted the resident paced and aimlessly wandered once or twice a week.</p> <p>A review of the Resident Sign in/out Record, dated 6/16/16, noted the resident signed out on 8:50 AM.</p> <p>A review of the Staff Every-2-hour Check Log, dated 6/16/16, noted the staff marked the resident was in A hall at 10 AM and in the dining room at 12 noon.</p> <p>Observation revealed resident #1 was at the state office building at this time.</p> <p>A review of social worker note dated 3/30/16 and 6/22/16, noted the contents were nearly identical: the resident did not report any plans to discharge from the facility in the near future and clinical staff did not anticipate his departure.</p>	F 280			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 280	Continued From page 9  On 6/3/16 at approximately noon, state employee S reported the resident walked in to a downtown state office building and looked for housing and food.  On 6/16/16 at 11:25 AM, state employee R reported the resident walked in to a downtown state office building and looked for food.  On 6/16/16 at 11:37 AM, surveyor Q observed the resident in a black T shirt and orange pants in a KDADS building. According to www.wunderground.com, it was 81 degrees Fahrenheit outside. The resident did not have a paper or pen, and he/she did not have any water. During the written interview, the resident was asked if he/she was thirsty, and stated he/she shook his/her head yes, and he/she was provided a drank a large Solo cup of ice water which he/she consumed within approximately 2 minutes. A second cup was provided and mostly consumed within a few additional minutes. The resident was unable to hear and unable to communicate verbally, but used a pen and paper for minimal communication.  On 6/16/16 at 11:49 AM, surveyor Q contacted the facility administrative staff A, and staff A stated he/she was not aware of the resident's current location, and neither did he/she know when the resident was expected to return.  On 6/16/16 at 3:14 PM, direct care staff L stated the resident frequently left the facility without signing out or notifying the staff.  On 6/21/16 at 9:36 AM, direct care staff M stated he/she was not aware where or when the resident left the facility on 6/16/16. Staff M added that	F 280			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 280	<p>Continued From page 10</p> <p>there was not any intervention for the resident leaving the facility.</p> <p>On 6/21/16 at 8:56 AM, licensed nursing staff G reported the staff did not always monitor the resident ' s departures.</p> <p>On 6/21/16 at 10:14 AM, social worker staff B confirmed the resident went out of the facility daily, and the resident did not always sign out on the paper upon leaving or returning. Staff B added the staff had not care planned the resident for discharge.</p> <p>On 6/21/16 at 10:51 AM, administrative nursing staff E stated the resident's behavior of leaving the facility had not changed, so he/she had not updated the resident's care plan after the incident of the departure to the metro city for 2 days.</p> <p>On 6/21/16 at 11:35 AM, administrative staff D stated the resident did not have a change in his/her behavior of leaving the facility.</p> <p>On 6/23/16 at 11:07 AM, during a phone interview, administrative nursing staff D was unable to answer if the care plan was updated after the incident of the resident missing for two days from 3/9/16 to 3/11/16.</p> <p>The facility failed to revise the care plan to reflect the interventions to keep the resident safe after the resident left the facility unattended for two days, and to follow the PASRR recommendations for the resident, who was mentally ill.</p>	F 280			
F 323 SS=J	<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</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 11</p> <p>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 83 residents with 3 residents sampled and reviewed for accidents. The facility failed to provide adequate supervision for 1 (#1) of the 3 residents reviewed when the resident left the facility for extended periods of time and during inclement weather when the resident left the facility during a heat advisory and severe weather alert. The facility also failed to provide assistive devices (paper and pen) to assist the resident, with deaf mutism (unable to hear or speak) in communicating his/her needs while out of the facility. Furthermore, the resident left the facility on 6/26/16, and was arrested by local police and incarcerated for criminal trespass and criminal damage to property. The resident remained incarcerated by local law enforcement on 6/30/16. The facility 's failure to provide adequate supervision while the resident was out of the building placed the resident in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- The physician's order sheet, dated June 2016, documented resident #1 admitted to the facility on 3/5/14 with diagnoses including schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought), major depressive disorder (major mood disorder), intellectual functioning disability (significant limitations in both intellectual functioning and in</li> </ul>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 12</p> <p>adaptive behavior, which covers many everyday social and practical skills), COPD (Chronic Obstructive Pulmonary Disease - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and deaf mutism (unable to hear or speak).</p> <p>The Annual MDS (minimum data set), dated 1/28/16, documented the resident's BIMS (brief interview for mental status score) of 99, indicating the resident was unable to complete the assessment. The staff assessment for mental status documented the resident's cognitive skills for daily decision making with modified independence with intact short and long term memory. The assessment identified signs of delirium including inattention (easily distracted and out of touch or difficulty following what was said) and disorganized thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas or unpredictable switching from subject to subject) both present and fluctuated. The assessment identified the resident had trouble concentrating on things present nearly every day. Staff identified the resident with behaviors including delusion (misconceptions or beliefs that are firmly held, contrary to reality) and other behaviors not directed toward others (examples include physical symptoms, pacing or rummaging) on 4-6 days out of 7. The resident did not exhibit wandering behaviors. The assessment identified independence in all ADL's (activities of daily living). The resident received antipsychotic, antianxiety, and antidepressant medications daily.</p> <p>The annual CAA (care area assessment), dated 1/28/16, for cognition documented the resident had diagnoses of depression, schizophrenia,</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 13</p> <p>anxiety and intellectual disability with deafness and required staff interviews for the BIMS assessment. According to staff, the resident was alert and oriented to name, location of his/her room, staff and peer faces. The resident presented with signs of inattention and disorganized thinking and communicated through gestures and writing with difficulty staying on topic. The resident answered best to yes or no questions. Because of the communication barrier and diagnoses the resident had difficulty in new situations and needed to be redirected appropriately. The CAA's for communication, psychosocial well-being, behavioral symptoms, and activities documented the same information as the cognition CAA, but also included because of the mental health diagnosis and intellectual disability, the resident had difficulty at times communicating his/her wants and needs. The CAA for psychotropic medication use documented the resident received scheduled psychotropic medication for schizophrenia, depression and insomnia. Staff currently monitored for behaviors which included isolation, delusions and sleeplessness.</p> <p>The significant change MDS, dated 3/31/16, documented resident with a BIMS score of 15, indicating cognitively intact. The assessment identified no signs of delirium, mood symptoms or behaviors and documented the resident's current behavior had improved from the previous assessment. The assessment identified independence in all ADL's (activities of daily living) except personal hygiene, which required supervision. The resident received antipsychotic and antidepressant medications daily.</p> <p>The significant change CAA, dated 3/31/16, for cognition did not trigger. The CAA for</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 14</p> <p>communication documented diagnoses of depression, schizophrenia, anxiety and intellect disability. The resident received scheduled prescribed medications which appeared to be effective. The resident was deaf and non-speaking and had hearing aids, which he/she chose not to wear all the time, and/or report that they were "broke" when they only needed new batteries. The resident communicated through writing and gestures, answered best to yes/no questions, but was able to make needs and wants known. The resident did not display any memory problems. The resident was independent with leaving the facility by him/herself and scored 15 on the BIMS assessment. There were no obvious signs of increased hearing abilities when wearing the hearing aids. Using written words, the resident was able to communicate his/her wants and needs effectively, but did continue to pursue his/her own thoughts independently and needed reminders to go through nursing for his/her appointments. The CAA for ADL's documented the same information but also included the resident was independent with ADL's with required occasional reminders to change a dirty shirt or comb his/her hair. The CAA for psychotropic medication use documented no change from the previous assessment CAA.</p> <p>The care plan, last updated 4/6/16, documented the resident, beginning 6/13/14, with cognitive loss and the potential for alterations in cognition due to his/her diagnoses. The resident had delusions and believed things about him/herself and his/her circumstances that were not true. The care plan directed staff if those things were not causing the resident to be agitated or upset, do not try to redirect as that could make the resident become upset. The resident walked up and down the halls and outside the building. The resident</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	Continued From page 15 knew where he/she wanted to go and what he/she was doing, but tended to pace occasionally while thinking about his/her plans. The resident previously lived in the community, therefore would take it upon him/herself to seek out community assistance independently. Staff educated the resident that while living in the facility, he/she did not qualify for cash assistance/food cards, but the resident continued to seek these services to increase his/her income. The resident wore a wet towel on his/her head under his/her hat when it was warm outside. The care plan directed staff to get the resident a towel for this if the resident asked for one. The resident did not have a history of elopement (the resident left the facility without staff knowledge for approximately 48 hours from 3/9/16 to 3/11/16). The resident was able to demonstrate signing in/out when he/she left the facility and could do so independently but may not always do this, and staff educated the resident on the importance. The resident had a tendency to take him/herself to hospitals/clinics out in the community to make his/her own appointments, and staff educated the resident to let them know when he/she need something. The resident also knew the facility doctors could take care of any issues as well. The resident was familiar with the surrounding community and frequently took him/herself around town on his/her bike. The resident had a history of not signing out. The resident had met with Social services and discussed ways the facility could assist with-out-of-facility appointments and the importance of notifying staff of when he/she will be returning. The resident was deaf, unable to speak, and usually communicated with sign language, gestures, lip reading, and writing. The resident can read so staff could write down on a whiteboard or piece of paper what they want to say to the resident if	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 16</p> <p>he/she had trouble understanding, or to help the resident tell staff what he/she needed. Staff educated the resident to drink plenty of fluids and take water with him/her while out walking in the community to stay hydrated, especially when the temperatures were warmer. The resident sometimes needed reminders to come out to meals. The care plan lacked interventions for the resident's unsafe wandering.</p> <p>The elopement risk assessment, dated 3/31/16, (22 days after the resident left the facility for 2 days without staff knowledge) documented the resident was alert and oriented and familiar with the community. The resident had in the past always made his/her own appointments while in the community. Staff encouraged the resident to allow nursing staff to assist him/her with making his/her appointments. The resident left the facility independently and knew he/she should sign in and out, but often chose not to.</p> <p>A review of the PASRR (Preadmission Screening and Resident Review: a federal requirement to help ensure that individuals with mental illness and intellectual/developmental disability were not inappropriately placed in nursing homes for long term care) determination letter from the Kansas Department for Aging and Disability Services (KDADS), dated 4/4/16, noted the resident benefited from staff's interventions to help decrease risk of wandering and the letter documented a group home or assisted living facility in the resident's care plan for discharge, so that he/she had a goal to transition back into the community.</p> <p>A review of the facility's incident report, dated 1/7/16 (incorrect date), recorded the resident left the facility on 3/9/16 at 6:45 PM and rode a bike</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 17</p> <p>to the bus station to go to a metropolitan city without staff's knowledge and the facility did not notify law enforcement until 10:00 PM. The metropolitan city police department located the resident on 3/11/16 at 12:57 PM. The report also noted the resident went to the metropolitan city for dental services.</p> <p>The elopement risk assessment, dated 5/18/16, documented the resident did not have elopement behaviors observed or noted.</p> <p>The elopement risk assessment, dated 6/15/16, documented no elopement behaviors noted. The resident was able to leave the facility independently and to demonstrate facility policy by using the sign and out sheet when he/she left. There were no issues noted when out of the facility.</p> <p>The behavior risk assessment, dated 3/31/16, documented the resident paced and aimlessly wandered once or twice a week.</p> <p>On 3/11/16, the state agency received a facility reported complaint alleging the resident left the facility without staff knowledge on 3/9/16 at approximately 6:45 PM, took a bus to a metropolitan area approximately 65 miles away. The investigation revealed law enforcement found the resident at that metropolitan area on 3/11/16 at 12:57 PM.</p> <p>Review of the local police department report revealed they issued a missing person's report for the resident on 3/9/16 at 11:23 PM. The report documented that facility staff stated to the reporting officer they were "not concerned about the subject; they were making the report for corporate to have." The report documented the</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 18</p> <p>metropolitan police department found the resident on 3/11/16 at 12:57 PM.</p> <p>The social serves note, dated 3/11/16 at 2:29 PM, documented the resident went to [the metropolitan area] to see the dentist and get his/her dentures fixed. The social worker explained to the resident he/she could get those serviced at the facility and he/she did not need to go to the metropolitan area for services. Social service staff explained the importance of communicating with staff his/her needs to get appointments set up and transportation arranged. The resident appeared to understand the information provided.</p> <p>On 6/13/16, the state agency received a second complaint at approximately 12:00 PM, the resident arrived at a location approximately 2.1 miles from the facility seeking food stamps and housing. Complainant R telephoned Administrative Staff A at the time who stated he/she did not know the resident 's whereabouts as the resident walked all over town. The complainant requested that the facility pick up the resident from that location at that time.</p> <p>According to www.wunderground.com, on 6/3/16 at 11:53 AM, the temperature measured 81 degrees Fahrenheit with a heat index of 82.7 degrees Fahrenheit.</p> <p>Review of the facility 2 hour resident check sheet, dated 6/3/16, revealed staff documented the resident was out of the facility at 10:00 AM and 12:00 PM.</p> <p>The facility failed to provide a copy of the sign out log, dated 6/3/16 for review.</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 19</p> <p>On 6/16/16, the state agency received a third notification by phone that the resident was again located at the same location as on 6/3/16. The resident was again seeking public assistance and food.</p> <p>On 6/16/16 the National Weather Service issued a heat advisory at 3:32 AM to remain in effect until 7:00 AM on 6/17/16. The National Weather Service defined a heat advisory as an expected prolonged period of hot temperatures. The heat and humidity would make heat related illness such as heat stress, heat cramps, and possibly heat stroke more likely. The combination of hot temperatures and high humidity would combine to create a situation in which heat illnesses were possible and directed people to drink plenty of fluids, and stay out of the sun. On 6/16/16 9:47 AM, the National Weather Service also issued a severe thunderstorm warning, with hail measured at 0.88 inches in size affecting the location where the resident was at that time.</p> <p>According to www.wunderground.com, on 6/16/16 at 8:53 AM, the temperature measured 77 degrees Fahrenheit, at 9:53 AM 73.9 degrees Fahrenheit with wind gust speeds at 25.3 mph (miles per hour) and light rain, at 10:53 AM 75.9 degrees Fahrenheit, and at 11:53 AM 80.1 degrees Fahrenheit with a heat index of 82.9 degrees Fahrenheit.</p> <p>Review of resident sign out log, dated 6/16/16, documented the resident signed out of the facility at 8:50 AM, with the destination documented as "walk of Kansas st".</p> <p>Review of the facility 2 hour resident check sheet, dated 6/16/16, revealed the resident documented as on Hall A at 10:00 AM, and in the dining room</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 20</p> <p>at 12:00 PM, when in fact observation revealed the resident was out of the facility at those times at the state office building.</p> <p>On 6/16/16 at 11:25 AM, observation revealed the resident at the above mentioned location, approximately 2.1 miles from the facility. The local public digital temperature, visible from the resident 's location, read 81 degrees Fahrenheit. The resident wore orange sweat pants, combat boots, and a black short sleeve shirt. He/she carried a backpack. The resident did not have a hat or towel on his/her head or water with him/her (as care planned). There was not a bicycle present with the resident. Through written communication, the resident indicated he/she walked to his/her current location, had signed out of the facility. When asked if he/she was thirsty, the resident shook his/her head yes. The surveyor provided the resident with a large Solo cup of ice water, which he/she consumed in a few minutes. The surveyor then provided the resident with a second cup of water, which he/she mostly consumed within a few additional minutes.</p> <p>On 6/16/16 at 11:49 AM, State Surveyor Q phoned Administrative Staff A to ask about the resident's whereabouts at that time. Administrative staff A stated he/she was not aware of the resident's current location, or when the resident was expected to return. The resident signed out that he/she went on his/her walk to "the state of Kansas building". Staff A was unsure of the temperature outside and stated the resident had towels on his/her head. Staff A stated, "He/She was usually good about these things".</p> <p>Observation of the facility door, on 6/16/16 at 1:45 PM, revealed the door lacked a sign alerting</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 21 residents to inclement weather.</p> <p>On 6/16/16 at 3:14 PM, direct care staff L stated the resident frequently left the facility without signing out or notifying the staff.</p> <p>On 6/16/16 at 4:50 PM, through written communication, the surveyor asked the resident if staff had reminded him/her to take towel and water that morning when he/she left the facility, the resident responded "yes" . However the resident did not have these items with him/her when observed out of the facility. When asked if staff alerted him/her to the bad weather that day, the resident responded "no".</p> <p>On 6/16/16 at 5:30 PM, observation revealed the resident entered the front door of the facility wearing a tank top and the same orange pants as earlier in the day.</p> <p>On 6/21/16 at 10:23 AM, Direct Care Staff N stated the resident was independent.</p> <p>On 6/16/16 at 4:00 PM, Administrative Social Service Staff B stated he/she had flash cards he/she showed the resident to assess the resident's BIMS. Staff B stated when the facility admitted a resident, staff observed the resident for 2 weeks for his/her safety awareness. This included observation for safety with smoking, ADL habits, preferences for meals, invited to outings to see behaviors, assessment for medication compliance and if the resident appeared to be able to follow directions. This resident was given written instructions on how to get somewhere, knew his/her way around the community and was very resourceful. Staff B stated the resident wore a towel under a cap and took a jug of water when he/she left the facility and there was a sign posted</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 22</p> <p>on the front door when there was a heat advisory or a thunderstorm warning. Staff B stated whoever checked the resident out today would have ensured the resident had his/her towel and a jug of water. Staff B felt the resident would know when he was thirsty and would know how to get something to drink. Staff B stated the resident would not necessarily have to check out with a staff member prior to leaving the facility. Staff B confirmed there were not any weather warnings posted on the door at the time. When asked to demonstrate the method used to assess the resident's cognition, Administrative staff B stated at 4:45 PM, he/she was not able to find the above mentioned flash cards used to perform the BIMS assessment. At 5:29 PM, Administrative Staff B stated the above mentioned 2 week assessment for safety awareness was not documented anywhere and stated it was only done on admission and if a resident's condition changed. Staff B did not think the resident's condition had changed since admission to the facility, therefore additional safety awareness assessments had not been completed on the resident. Staff B was not aware of a date or policy for posting inclement weather to alert the residents who left the facility.</p> <p>On 6/16/16 at 4:03 PM, Licensed Nursing Staff H stated when the residents wants to go out, they needed to sign out on the log sheet and document the time, location, mode of transportation, and expected time of return. If Staff H was unable to locate a resident in the building, he/she would check the sign out sheet to see if the resident had signed out of the building. However, some residents forget to sign out or alert the nurse that they are leaving. Staff H stated the facility used 2 hour visual checks to identify if a resident was missing. If that happened, all staff looked everywhere, and sent a</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 23</p> <p>van with a CNA (certified nursing assistant) to go out and look for the missing resident. Staff H would then alert the administrator and may alert the police as indicated. No one had been missing recently that Staff H was aware of. Staff H always reminded residents to sign out when they leave. Staff H stated the facility curfew was 10:00 PM, and if a resident was not in the facility after 10:00 PM, staff called the police. If the weather changes, the staff would try to locate the residents who are out of the facility and pick them up. The MDS nurses assess and decide if the residents were alert and oriented enough to go out unattended. Staff H was not aware of safety awareness assessments.</p> <p>On 6/16/16 at 5:30 PM, Licensed Nursing Staff I stated he/she had never seen a sign on the door or wall warning the resident's about inclement weather, storms or heat.</p> <p>On 6/16/16 at 5:10 PM, Licensed Nursing Staff J stated all residents should sign out when they go out of the building, but sometimes they forget to. Staff used the 2 hour visual rounds to determine if a resident was out of the building that had not signed out. If a resident was missing, everyone looked for that person and we will notify the DON. Staff J stated the facility did not have an inclement weather sign to alert resident's to potential harmful weather when they were out of the building.</p> <p>On 6/16/16 at 5:15 PM, Direct Care Staff L stated staff were expected to warn residents of the heat or of thunderstorms before the resident left the facility and denied knowledge of a sign posted for this. Staff L stated in the event of severe weather, staff were expected to go pick up residents who were out of the building. Staff L stated residents</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 24</p> <p>were to write down where they were going when they left the building so this can be done. Staff L was aware of towel and water on resident's care plan for leaving in hot weather.</p> <p>On 6/16/16 at 5:37 PM, Administrative Nursing Staff E stated he/she performed elopement risk assessments for residents quarterly. Staff E performed an elopement risk assessment for mental health when the resident returned from the metropolitan area. Staff E stated when residents were admitted, they were observed for safety awareness and the level of assistance needed. The resident's safety awareness was reassessed every year and with a change in their condition. Staff E stated the safety awareness was the MDS. Staff E stated the resident's mental health status had not changed since his/her admission to the facility in 2014.</p> <p>On 6/16/16 at 5:53 PM, Administrative Nursing Staff D stated there was signage written down and made if there was a heat or cold advisory. The nursing staff on duty were responsible for alerting the residents to inclement weather or a heat/cold advisory. Administrative Nursing Staff D did not feel there was a change that warranted reassessing safety awareness after the resident went to the metropolitan area without staff knowledge in March, and was gone from the facility for approximately 48 hours.</p> <p>On 6/23/16 at 11:07 AM, during a phone interview, administrative nursing staff D stated the nurses should notify the physician for missed medication doses. He/she was not aware the resident frequently missed nebulizer treatments.</p> <p>On 6/16/16 at 5:55 PM, Administrative Staff A stated he/she had not reported the above</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 25</p> <p>mentioned incidents on 6/3/16 and 6/16/16 to the State Agency, because the resident left on his/her own all of the time and usually had a towel and a jug of water. Staff A stated the resident did not write down a specific destination on 6/16/16, but Staff A suspected the resident went to the same building as he/she had done last week, on 6/3/16. Administrative Staff A stated the facility did not have a set plan for identifying when a resident had not returned to the facility, because it was all based on the resident's individual pattern. If the resident usually came back at noon, then the facility would expect him/her to be back at noon and would be concerned if he/she was not back by that time. Administrative Staff A stated the resident's pattern was he/she left the facility in the morning, came back to eat at noon, and left again in the afternoon.</p> <p>On 6/21/16 at 7:46 AM, Complainant R stated on 6/3/16, he/she was headed out from work for lunch around noon, and State Employee S reported to Complainant R that the resident was at their office building. Complainant R stated the resident did not speak, so they communicated with writing on note pads. The resident indicated he/she needed a vision card (state assistance for food). State Employee S then walked the resident down the street to the appropriate state agency, at which time the resident indicated he/she needed a place to stay. Staff from that agency then determined the resident lived in the facility. At that time, Complainant R called Administrative Staff A and asked if he/she knew the resident's whereabouts. Administrative Staff A replied, "No, the resident walked all over the town". Complainant R asked State employee S to remain with the resident until the facility arrived to pick up the resident and return him/her to the facility. Complainant R stated it was warm that</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 26</p> <p>day, and the resident had a bag with random stuff in it, and no water. The resident wore a long sleeve shirt, long pants, had no hat and no towel. Complainant R stated it was not the first time the resident had come to this location. Complainant R stated on 6/16/16, around 11:00 AM, State Employee S again reported the resident was there.</p> <p>On 6/21/16 at 8:56 AM, Licensed Nursing Staff G stated the staff did not always monitor the resident's departures.</p> <p>Observation of the sign out log, on 6/21/16 at 9:00 AM, located at the nurse's desk in front of the front door of the facility revealed a sheet with the following column headings: Resident; Date Out; Time; Date Returned; Expected Time of Return; Actual Time of Return; Destination; Responsible Party &amp; Phone Number. The current sheet, dated 6/21/16 documented Resident: "[last name]" , Out: "8:15" , Actual Time of Return: "8:45" , Destination: "bike".</p> <p>On 6/21/16 at 9:01 AM, the front of the facility revealed a double door that exited to a patio and parking area in front of the facility. Posted on the inside left door a sign stated the following: Inclement weather: Heat advisory (in large bold print): Due to the current weather conditions we recommend that you do not leave the facility. If you choose to leave, please go to the nurse's station for instructions (in fine small print at the bottom of the sign).</p> <p>On 6/21/16 at 9:02 AM, observation revealed the resident rode a bicycle in the parking lot of the facility. He/she entered the front door, wore black shorts, a black t-shirt, black boots, and a pink bandana on his/her head. The resident had no</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 27</p> <p>bag or backpack with him/her, no water, no pen or paper, and had a pack of cigarettes visible tucked in the waist band of the shorts. The resident walked to his/her room.</p> <p>On 6/21/16 at 9:22 AM, the resident approached the nurse's desk from his/her room. Administrative Staff A stood at the desk. The resident picked up the pen for the sign out log and laid it back down without documenting anything and exited the building through the front door. Administrative Staff A followed the resident out the door. The resident and Administrative Staff A returned to the building, the resident walked down the hall to his/her room and returned to the nurse's desk with a large (approximately 44 oz) black water cooler. Administrative Staff A exchanged written notes with the resident at that time. The note read: "Do you know when you will be back" . Written Response: "When did cross housing in to catch on a back side". When asked what that response meant, Administrative Staff A stated, "I assume that means he/she is going up by the housing authority because that is where he/she always goes" . When asked, "So, based on the assumption, you really do not know where the resident is going?" Administrative Staff A responded, "He/she does not tell have to tell me where he/she is going, because he/she was independent, knows where he/she was going and what he/she was going to do, so I do not have to do anything."</p> <p>On 6/21/16 at 9:36 AM, Direct Care Staff M stated he/she was not aware where or when the resident left the facility on 6/16/16. Staff M added that there was not any intervention for the resident leaving the facility.</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 28</p> <p>On 6/21/16 at 10:47 AM, the resident walked out the front door of the facility without communicating with staff (6 administrative, licensed and direct care staff were visible from the nurses desk at that time), or signing the log, got on a bicycle and began riding around in front of the facility. Administrative Staff A followed the resident out the front door and immediately returned to the nurse ' s desk. Administrative Staff A took the sign out log outside to the resident who remained on his/her bicycle. Administrative Staff A returned with the sign out log and laid it on the nurse ' s desk. Review of the log revealed "[resident's last name]", date out "6/16", at time "10:48", destination "Bike". Observation revealed the resident rode off the facility grounds on the bicycle, without water or a backpack to carry items such as a towel or pen and paper, and remained in the same clothes as previously documented.</p> <p>On 6/21/16 at 11:25 AM, observation revealed the resident walked into the facility though a back door, out of the dining room and down the hall where he/she resided, with a plastic store bag in his/her hand. The resident's face was visibly red, and there were visible beads of sweat on the resident ' s face and arms and the resident's black t-shirt (back and front) was visibly wet in a "V" pattern extending from the shoulders down to the bottom of the shirt. The resident did not have a backpack or jug of water with him/her at this time. Administrative Nursing Staff A and Licensed Nursing Staff G were at the nurse's desk at this time. Administrative Nursing Staff A looked at the sign out log at this time, which still did not have a time of return to facility documented and stated to the Licensed Nursing Staff G, "He/She was back, he/she had been back for a while, he/she went to the store." Licensed Nursing Staff G responded,</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 29</p> <p>"Yeah, I see him/her right there", and gestured by nodding his/her head in the direction of the resident as the resident walked down the hall to his/her room.</p> <p>According to www.wunderground.com, on 6/21/16 at 10:53 AM, the temperature recorded at 87.1 degrees Fahrenheit with a heat index (what the temperature feels like to the human body when relative humidity is combined with the air temperature) of 92.8 degrees Fahrenheit. At 11:53 AM, the temperature documented at 89.1 degrees Fahrenheit with a heat index of 96 degrees Fahrenheit.</p> <p>On 6/21/16 at 8:56 AM, Licensed Nursing Staff G stated the resident's let staff know when they were going to leave and return, most sign out but it was their right not to if they did not want to. Staff G stated the resident would sign out, but does not always, sometimes he/she communicated instead by writing notes. Staff G stated the resident had a pattern of riding his/her bike, usually in the morning and liked to go for a walk in the afternoon. Staff G stated he/she usually had to ask the resident where he/she was going and when he/she planned to return. But, the resident did not have to tell staff, because that was his/her right and he/she was independent. Staff stated the resident had a pen and paper he/she used to write communications, but staff did not make sure he/she had that when he/she left the building. On the 6/16/16, staff confirmed being the nurse on duty and stated the resident signed out and wrote he/she was going to "Kansas". Staff G stated that meant the resident was going to try and get food stamps. Staff G was not sure how often the resident had done that, but more than once. Staff recalled that when the resident left that day it had just rained a little bit and the temperature was in</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 30</p> <p>the mid 80's. If he/she was leaving the building, we always make sure to check clothing and make sure he/she is properly dressed. Most of the time the resident wore a hat or bandana when it is was hot and had a wet rag or towel on his/her head. Staff G did not check the resident before he/she left that day. Staff G stated whatever staff were at the nurse's desk when a resident leaves was responsible to check the resident. Staff G stated that in this resident's specific case, he/she was his/her own person and staff did not have to monitor his/her coming and going. Staff G was not aware the resident did not have water on 6/16/16. Staff G further stated there had not been any changes in his/her needs or care since he/she admitted to the facility in 2014, 2 years ago. The aides that were assigned to a hall were responsible for that hall's 2 hour checks. The expectation is that they start 2 hour rounds on the even hour, and they were supposed to set eyes on each resident. If they did not see the resident they are supposed to report that to the charge nurse immediately. Staff G reviewed the 2 hour check sheet for 6/16/16 and confirmed the CNA did not put eyes on the resident a 10 and 12 because staff G remembered the resident signing out around 8:00 AM and coming back to the facility sometime after lunch, stating the CNA documented the resident was in the building when in fact he/she was not.</p> <p>On 6/21/16 at 9:36 AM, Direct Care Staff M stated the resident was independent and does not require much attention. We look at sign out sheet to know when a resident is leaving and returning to building and we do 2 hour checks as a back-up if someone does not sign out, they are done on everyone. The CNA for a hall was responsible for the 2 hour check sheet on that hall. Staff M does a head count, looks for</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 31</p> <p>everyone on the sheet and documents where they are at that time. If someone was not here, staff M reports to charge nurse who deals with it from there. Staff M stated the nurses may know more about where a resident was because they know the resident ' s better than Staff M. Staff M confirmed working with the resident on 6/16/16, and did not know he/she had left the building. Staff M stated Direct Care Staff O was responsible for the 2 hour visual checks for the resident on 6/16/16. Staff M was not aware of where the resident went when he/she left the facility. Staff M stated he/she did not do anything specifically for the resident when he/she left the building because the resident was independent and Staff M does not have to. Staff M stated the charge nurse was to notify the resident if it was hot out and make sure he/she had a jug of water. Staff M stated he/she did not know how long staff had been doing that for the resident, but thought it was new. Staff M stated he/she saw the resident come and go all the time from the facility and he/she usually did not have a jug of water with him/her when he/she left. Staff M stated the resident communicated with staff in writing and Staff M cannot always understand what the resident writes. Staff M stated the facility staff does not worry about how long the resident was gone because he/she was independent and knew how to take care of himself out there. Staff M was aware of the heat advisory on 6/16/16, but did not know if anyone warned the resident about it. Staff M was not aware the resident did not have water on 6/16/16 when he/she left the building.</p> <p>On 6/21/16 at 9:52 AM, Direct Care Staff O stated the resident used a sign out sheet to let staff know when he/she was leaving, and most of the time he/she uses it. Sometimes he/she puts where he/she was going. The CNAs were</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	Continued From page 32 responsible for monitoring that he/she had signed out. Staff O state the resident had the same routine of leaving after breakfast, but staff O did not know where the resident goes. There are days when he/she was gone 15 minutes and other days when he/she was gone all day. Staff O stated the resident was independent and staff did not have to monitor when he/she goes, or where he/she goes. He/she leaves and comes back frequently throughout the day. When asked if there was anything specific staff do for the resident when he/she left the building, staff O stated the resident was pretty good about taking care of things him/herself, so there was nothing staff do to prepare him/her to go out. Staff O confirmed he/she worked on 6/16/16 and was responsible for the 2 hour log for the resident that day. Staff stated he/she set eyes on each resident and document using the key where they are. While reviewing a copy of the log sheet for 6/16/16 staff O confirmed that the documentation from 6:00 AM to 2:00 PM was his/her writing. Staff confirmed 10:00 AM documented the resident was on A hall and 12:00 PM documented the resident was in the dining room, and the resident was out of the building when Staff O documented he/she was in the building. Staff O stated he/she had taken care of the resident since he/she admitted in 2014, and his/her ability and care had not changed in that time. We are all responsible to make sure he/she had appropriate dress and water when he/she leaves and staff did not know why the resident did not have water and protective appropriate clothing on 6/3/16 or 6/16/16. Staff stated the resident communicated to people by writing, but staff do not make sure he/she had anything to write with because the staff are the one that usually had those items on them.	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 33</p> <p>On 6/21/16 at 10:14 AM, Administrative Social Services Staff B stated the facility provided the resident with the structure and activities the facility offered and he/she provided 1:1 when needed, which was done when the resident seeks it out. Staff confirmed it was common for the resident to go into the community daily and the resident communicated in written form with people. The facility staff provided pen and paper but it was up to the resident if he/she chose to take it with him/her when he/she left the building. Staff B stated he/she recently became aware that the resident was seeking out housing, food, and assistance in the community, and stated he/she had educated him/her that Staff B could provide those things for the resident here at the facility. Staff B stated if the resident was not familiar with the person attempting to communicate with him/her (out in the community for instance), and if that person did not know sign language, the resident was not going to communicate with that person (making communication about the resident's needs difficult).</p> <p>On 6/21/16 at 10:51 AM, Administrative Nursing Staff E stated the resident had not had any changes in his/her abilities, his/her needs or care required by staff. Administrative Nursing staff E stated he/she was responsible for updating the care plan and had not made any updates to the resident's care plan in relationship with his/her leaving the facility. Staff E stated there was nothing to update about his/her leaving, because it was normal for him/her to leave. Staff E stated if there was a reason to alert the resident, like bad weather, staff could do that, but once the resident was out in the community, he/she made his/her choices where he/she wanted to go and what he/she wanted to do. Staff E stated, we have no concern with that.</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 34</p> <p>On 6/21/16 at 11:23 AM, Administrative Social Service Staff B stated there were no formal flash cards used to assess cognition with the resident as he/she had previously stated. Instead, he/she wrote down the 3 words used in the assessment on the paper, and wrote remember and repeat, and the resident was able to do so. This was repeated for the time, and the year. When asked to demonstrate the process, Staff B stated he/she was not comfortable doing that and felt it was inappropriate to demonstrate the assessment of the resident's cognition to the state agency.</p> <p>On 6/21/16 at 2:42 PM, Consultant Practitioner V stated the resident had COPD, hyperlipidemia, schizophrenia, deaf mutism, intellectual disability, insomnia, and major depression. The reason the resident required nursing home placement were the diagnoses of schizophrenia, intellectual disability and depression required nursing care. He/she is in a place that they can say, "Here are your meds", that way he/she stays on them. Consultant Practitioner V stated the resident could read notes a little bit, when asked he/she occasionally said yes or no or gave a thumbs up, so Consultant Practitioner V felt like the resident was understanding enough to answer those questions. When asked about the resident's cognitive ability and safety awareness, Consultant Practitioner V stated his/her focus was more on the resident's physical needs, and those concerns would be better addressed by the practitioner who saw the resident for mental health. Consultant Practitioner V stated the facility reported to him/her that the resident had been gone from the facility and was back, that was all they knew about the situation.</p> <p>The patient cases note, dated 3/16/16 (7 days</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 35</p> <p>after the resident left the facility), documented the following communication to Consultant Practitioner V: the patient went to the bus station and bought a ticket to a metropolitan area. He/she was found by the police. He/she was transported back to the facility. (the notification failed to identify the resident had been gone for 2 days and lacked any details).</p> <p>On 6/24/16 at 10:50 AM, Consultant Practitioner W stated he/she had provided mental health care for the resident since his/her admission to the facility and saw the resident approximately every other week. Consultant Practitioner W stated the resident had chronic schizophrenia and had declined a lot since he/she first began treating the resident. Consultant Practitioner W stated the resident cannot even maintain a simple sustained conversation, even in written form, and struggles with simple yes and no questions when he/she sees the resident. When asked about the resident's cognitive ability, Consultant Practitioner W stated the resident was barely above minimal functioning and definitely had far below average abilities. Consultant Practitioner W was not aware the resident had left the facility without staff knowledge for 2 days in March 2016 and stated he/she was very concerned about the resident's safety when out of the building and in the community. Consultant Practitioner W stated he/she wanted the resident to maintain as much independence as possible, but it had to be done safely and he/she questioned the residents' ability to do so stating the resident lacked the ability to seek shelter in a storm, take precautionary measures if it was excessively hot outside or communicate his/her needs effectively out in the community. Consultant Practitioner W felt the facility needed to develop a plan to monitor the resident's whereabouts if he/she left</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 36</p> <p>the building, and had concerns with the facility not knowing where the resident was in the community or how long he/she would be gone.</p> <p>On the morning of 6/30/16, Corporate Consultant Y contacted the state agency to inform that the resident had been arrested. No other information was given at that time.</p> <p>The Kansas Standard Arrest Report, dated 6/26/16 at 10:47 AM, documented police responded to a local home with report of a burglary. The victim stated the suspect (the resident) had forced entry into the home from the back door while the victim was in front of the home tending to his/her plants. The victim went inside his/her home to find the suspect (the resident) in the kitchen of his/her home. The suspect (the resident) ran out the back door. Later, while police were speaking to the victim, the suspect (the resident) walked up to the home and the suspect (the resident) was detained and taken to the local law enforcement center for questioning.</p> <p>The local Police Department Affidavit, dated 6/26/16, documented the resident allegedly committed criminal trespass and criminal damage to property. The back door of the home appeared to be forcefully opened by the suspect (the resident) as there was a padlock on the floor by the door with the latch that had been connected to the door still attached to the padlock. The victim had taken a picture of the suspect (the resident) and showed it to the police officer. A sergeant made contact with the facility where the resident lived and confirmed the resident was deaf and had several mental issues.</p> <p>The local Police Department Supplemental</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	Continued From page 37 Offense Report, dated 6/26/16, documented the resident lived at the facility, which was for mentally challenged adults but had the ability to come and go as he/she pleased from the facility. When the police department dispatch attempted to contact the facility, they were unable to reach anyone at the facility by phone. A sergeant went to the facility and spoke with Licensed Nursing Staff G, who advised that the resident had left the facility earlier in the day and was not due for his/her medication again until 6:00 PM. Staff stated the resident was deaf and could not speak. He/she read lips very well but would pretend to not be able to do so when it was to his/her advantage, but was able to read and write. That was how the staff member communicated with the resident. The facility staff gave the sergeant a copy of the resident ' s medical record face sheet, which included his/her diagnoses. When the sergeant returned to the jail, he/she asked the resident if he/she understood sign language and he/she shook his/her head " no ". The sergeant communicated to the resident by writing and the resident wrote something down, but it made very little sense when the sergeant read it. The note made reference to being in the wrong place. A copy of the note was included in the case file. The resident had a wooden box in his/her possession when he/she was arrested. The wooden box contained a grey box, with cigarettes, a pink bandana, remote control, ointment, one dollar, a lighter and a silver compact. Also in the wooden box was a snoopy fishing pole, a black water jug and a ball cap. These items were returned to Licensed Nursing staff G at the facility. At that time, another staff stated the wooden box did not belong to the resident. It was unknown at that time if he/she stole this item. Licensed Nursing Staff G stated to the officer that the resident would not be able to	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 38</p> <p>return to the facility at this time, the resident understood what he/she was doing and knew he/she was in trouble and was " playing off " as though he/she did not understand.</p> <p>Review of the above referenced note used to communicate with the resident by the officer revealed the following: Officer: " [resident's name], I need to know about what happened at the house on [city street]. Write down what you did there. " Resident: " Maybe housing lock a p [scribble] [scribble] back in place wrong to forget it [scribble] [scribble] ask someone [scribble] slow down. "</p> <p>In the afternoon on 6/30/16, State Surveyor Q spoke with the local jail and confirmed the resident remained in the jail at this time. The resident was being held on \$1000 bond, and sentencing was set for October 5, 2016.</p> <p>A meeting was held regarding the status of the resident on 6/28/16 from 1:00 PM to 3:00 PM and included state agency staff as well as Administrative Staff A, Administrative Nursing Staff D and Corporate Consultant Y. At no point during the meeting did facility staff bring to the state agency attention that the resident had been arrested 2 days prior, and remained incarcerated at that time.</p> <p>The facility provided policy for elopement, undated, documented staff ensured that each resident received adequate supervision and assistive devices to prevent elopement.</p> <p>The facility provided policy for signing residents in and out, undated, documented all residents were requested to sign out when leaving the premise.</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	<p>Continued From page 39</p> <p>The facility requested each resident leaving the community to sign out and to notify the staff they were no longer in the building.</p> <p>The facility failed to provide measures to maintain safety for this resident with intellectual disabilities and deaf mutism, and assistive devices to aid in communication when the resident left the facility. The resident was gone from the facility without staff knowledge on 3/9/16 for approximately 48 hours. After that incident, the resident continued to leave the building for undetermined lengths of time, with undetermined destinations and had done so during inclement weather without water to drink, appropriate protective clothing, or any adaptive device to assist the resident with communicating his/her needs to the general public. Furthermore, the resident left the facility on 6/26/16, and was arrested by local police and incarcerated for criminal trespass and criminal damage to property. The resident remained incarcerated by local law enforcement on 6/30/16. The facility failed to develop and implement timely and effective interventions to ensure the resident's safety when he/she left the facility independently, for extended periods of time and in inclement weather, placing this resident in immediate jeopardy.</p> <p>The facility abated the immediate jeopardy, on 6/30/16 at 6:30 PM, by initiating the following: Signage was made and placed on doors for notification of inclement weather. Staff educated on resident's leaving in inclement weather, appropriate clothing and fluids educating resident's regarding signing out and in, offering a means of communication to hearing impaired when leaving the building. All residents were re-evaluated to determine ability to leave the facility safely without staff supervision and care</p>	F 323			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 323	Continued From page 40 plans were updated.  This immediate jeopardy was abated on 6/30/16 at 6:30 PM, however the deficiency remained at a scope and severity of a D.	F 323			
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES  If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.  This Requirement is not met as evidenced by: The facility identified a census of 83 residents. The sample included 3 residents. Based on observation, interview and record review, the facility failed to provide required services as identified in Preadmission Screening and Resident Review (PASRR: a federal requirement to help ensure that individual with mental illness and intellectual/developmental disability, were not inappropriately placed in nursing homes for long term care) for 1 of 3 residents (#1), diagnosed with mental illnesses.  Findings included:  - The June 2016 Physician Order Sheet (POS) for resident #1 included diagnoses schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought),	F 406			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 406	<p>Continued From page 41</p> <p>major depressive disorder (major mood disorder), intellectual functioning disability (significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills), COPD (Chronic Obstructive Pulmonary Disease - progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and deaf mutism (unable to hear or speak). The POS also included a Duoneb albuterol (used to treat COPD) a nebulizer(device which changes liquid medication into a mist easily inhaled into the lungs) 3 times a day</p> <p>The annual Minimum Data Set (MDS) dated 1/28/16, recorded the resident had a level II PASRR for serious mental illness and intellectual disability. The resident had highly impaired hearing, did not have speech, and he/she had intact short and long term memory. He/she did not exhibit wandering. The resident exhibited delusions and behaviors toward self. The resident had modified independence with decision making.</p> <p>The significant change MDS dated 3/31/16 revealed the resident had a level II PASRR for serious mental illness and intellectual disability. The resident had highly impaired hearing and did not have speech. The resident had a Brief Interview for Mental Status score of 15 indicating intact cognition. He/she did not exhibit wandering behaviors.</p> <p>The Care Area Assessment (CAA) dated 3/31/16 for psychotropic drug use revealed the resident was deaf and non-speaking. The resident had diagnoses of depressive disorder, schizophrenia, anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and intellectual disability, and</p>	F 406			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 406	<p>Continued From page 42</p> <p>he/she received scheduled prescribed medications.</p> <p>The care plan dated 4/6/16, noted the resident had delusions(untrue persistent belief or perception held by a person although evidence shows it was untrue) due to the disease, staff were not to redirect him/her as the interventions could worsen the behaviors; the resident did not have a discharge plan from the facility. The resident had a diagnosis of COPD, and he/she received nebulizer breathing treatments, which staff administered as the physician ordered. The care plan lacked interventions for the resident's unsafe wandering.</p> <p>A review of PASRR determination letter from Kansas Department for Aging and Disability Services, dated 4/4/16, noted the facility staff administered and monitored for effectiveness and side effects of the medications for the resident; the resident benefited from staff's interventions to help decrease his/her risk of wandering. The facility documented a group home or assisted living facility was in the resident's care plan for discharge, so that he/she had a goal to transition back into the community.</p> <p>A review of the facility ' s incident report, dated 1/7/16( incorrect date), recorded the resident left the facility on 3/9/16 at 6:45 PM and rode a bike to the bus station to go to a metro city without staff's awareness and the facility did not notify the law enforcement until 10:00 PM.</p> <p>A review of the incident report from the local police department, dated 3/9/16, recorded the facility contacted the law enforcement at 10:45 PM and reported that the resident was missing since 2 PM on 3/9/16. The facility staff was not</p>	F 406			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 406	<p>Continued From page 43</p> <p>sure if the resident rode a bike or what he/she wore that day. The report noted the facility staff did not express concern of the resident, and he/she needed the police report for the corporate use. The report also noted the Metro city police contacted the facility on 3/11/16 at 12:57 PM when they found the resident.</p> <p>A review of the Behavior Risk Assessment, dated 3/31/16, noted the resident paced and aimlessly wandered once or twice a week.</p> <p>A review of the Resident Sign in/out Record, dated 6/16/16, noted the resident signed out at 8:50 AM.</p> <p>A review of the Staff Every-2-hour Check Log, dated 6/16/16, noted the staff marked the resident was in A hall at 10AM and in the dining room at 12 noon. Observations revealed resident #1 was at the state office building at this time.</p> <p>A review of social worker notes dated 3/30/16 and 6/22/16, noted the contents were nearly identical: the resident did not report any plans to discharge from the facility in the near future and clinical staff did not anticipate his departure.</p> <p>A review of the Treatment Administration Record, in April 2016 the resident was not available for the nebulizer (device which changes liquid medication into a mist easily inhaled into the lungs) treatments once, and refused 5 times; in May 2016, the resident was not available once, and refused 10 times; and in June 2016, the resident was not available for 4 times, and refused 4 times. These missed treatments occurred on different shifts.</p> <p>The clinical record lacked evidence of</p>	F 406			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 406	<p>Continued From page 44</p> <p>notifications to the physician regarding the frequently missed nebulizer treatments mentioned above.</p> <p>On 6/3/16 at approximately noon, state employee S reported to the state agency the resident walked to a downtown state office building looking for housing and food.</p> <p>On 6/16/16 at 11:25 AM, state employee S reported the resident walked in to a downtown state office building and asked for food.</p> <p>On 6/16/16 at 11:37 AM, surveyor Q observed the resident in a black T-shirt and orange pants in a state office building. The resident did not have a paper or pen, and he/she did not have any water. During the written interview, the resident stated he/she was thirsty, and he/she drank a large glass of ice water within 2 minutes. The resident was unable to hear and unable to communicate verbally, but used a pen and paper for minimal communication.</p> <p>On 6/16/16 at 11:49 AM, surveyor Q contacted the facility administrative staff A, and staff A stated he/she was not aware of the resident ' s current location and neither did he/she know when the resident was expected to return to the facility.</p> <p>On 6/16/16 at 3:14 PM, direct care staff L stated the resident frequently left the facility without signing out or notifying the staff.</p> <p>On 6/21/16 at 9:36 AM, direct care staff M stated he/she was not aware where or when the resident left the facility on 6/16/16. Staff M added that there was not any intervention for the resident leaving the facility.</p>	F 406			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 406	Continued From page 45  On 6/21/16 at 8:56 AM, licensed nursing staff G reported the staff did not always monitor the resident's departures.  On 6/21/16 at 10:14 AM, social worker staff B confirmed the resident went out of the facility daily, and the resident did not always sign out on the paper upon leaving or returning. Staff B reported the PASRR documented the resident had a behavior of wandering was inaccurate because the resident did not wander. He/she added he/she just became aware the resident sought food, housing and assistance in the community on June 3, 2016. Staff B also added the staff had not care planned the resident for discharge.  On 6/23/16 at 10:55 AM, during a phone interview, licensed nursing staff K reported the medication should be offered in a later time but within the schedule time frame when the resident was not available or refused the medication. If the medication was not administered, the staff should notify the physician and document in the nurse's notes. Staff K also stated he/she was not sure if staff notified the physician regarding the frequently missed nebulizer treatments.  On 6/22/16 at 10:00AM, during a phone interview, administrative nursing staff D reported the facility lacked a policy for PASRR. Staff D also stated how soon the facility contacted the law enforcement for a missing resident was based on the individual's normal routine when the resident was outside the facility.  On 6/23/16 at 11:07 AM, during a phone interview, administrative nursing staff D stated the nurses should notify the physician for missed	F 406			

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

Printed: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E528</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C <b>07/05/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>COUNTRYSIDE HEALTH CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>440 SE WOODLAND AVE TOPEKA, KS 66607</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 406	Continued From page 46 medication doses. He/she was not aware the resident's frequently missed nebulizer treatments.  The facility failed to provide interventions identified by the PASRR to obtain the highest level of medication management, functional and psycho-social well-being, and discharge back to the community for the resident, who was deaf and mentally ill.	F 406			