

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

PRINTED: 01/19/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>VALLEY HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088</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 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had 35 residents. Based on observation, interview, and record review, the facility failed to ensure the most recent survey results remained available for examination and readily accessible to residents, without having to ask to see them.</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- An observation on 1/12/16 at 9:50 a.m. revealed a sign posted by the facility business office that informed residents, family, and visitors that state survey inspection results were available upon request from the office staff.</li> </ul> <p>During an interview on 1/12/16 at 9:55 a.m.,</p>	F 167			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1 activity staff W verified residents must ask facility staff to view the state inspection results and confirmed the results were not placed in a location easily accessible to residents.	F 167			
F 223 SS=D	<p>The facility failed to ensure the state survey results remained available for examination and readily accessible to residents.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to ensure that residents were free from verbal and physical abuse from 1 (#8) of 2 residents sampled for abuse.</p> <p>Findings included: - Review of resident #8 's physician order sheet dated 7/16/15 indicated diagnoses of mood disorder (a psychological disorder characterized by the elevation or lowering of a person ' s mood) and borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships and self-image along with impulsive, reckless, and often self-destructive behavior).</p>	F 223			

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F 223	<p>Continued From page 2</p> <p>Review of the admission minimum data set (MDS) dated 7/23/15 revealed a BIMS (brief interview for mental status) score of 15 which indicated intact cognition. According to the assessment, the resident had clear speech and was able to understand and be understood. Assessment revealed a mood interview score of 0 which indicated no depression. The resident did not exhibit any signs or symptoms of delirium or psychosis and rejection of care was not exhibited. The resident was independent in all activities of daily living and in bathing and had a steady gait with no mobility devices in use.</p> <p>Review of the quarterly MDS (minimum data set) dated 10/5/15 remained unchanged from previous assessment except for the mood interview score of 1 which indicated mild depression.</p> <p>The care area assessment (CAA) for psychotropic medication use dated 8/3/15 indicated the resident was on several psychotropic medications and had diagnoses of Schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) and explosive personality disorder (repeated, sudden episodes of impulsive, aggressive, violent behavior or angry verbal outbursts in which one reacts grossly out of proportion to the situation). The resident was identified as becoming easily upset and having to talk him/herself down before he/she "hurts" someone. The staff were to monitor behaviors each shift, report side effects to the physician, have pharmacy reviews monthly and have the psychiatry nurse practitioner visit monthly.</p> <p>The resident's care plan dated 7/16/15 identified the resident had a mood disorder and explosive personality disorder with a goal to maintain</p>	F 223			

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F 223	<p>Continued From page 3</p> <p>his/her personal care needs and safety effectively. The interventions in place directed staff to administer antipsychotics as prescribed and monitor the side effects of medications. A revision on 8/11/15 directed staff to encourage the resident to voice his/her feelings to his/her guardian, allow the resident to go outside to pray when angry, encourage the resident to verbalize his/her feelings before he/she becomes too upset to deal with situations, and to acknowledge the resident tends to become verbally aggressive toward peers and staff when he/she does not have immediate gratification.</p> <p>The resident's care plan dated 7/16/15 identified the resident had trouble controlling his/her anger and directed staff to allow the expression of feelings, encourage socialization, and provide time for the resident to express needs and wants. A revision on 1/7/16 directed staff to encourage the resident to remove self from situation when he/she is angry, encourage the resident not to call family when he/she is angry as it escalates his/her behaviors, remind the resident to inform staff when situations cause anger instead of taking care of it on his/her own, remind the resident of the facility policy of not lending or borrowing money or other items from other residents, and to remind the resident of the facility groups such as anger management or stress relief that he/she can attend to help him/her cope with anger issues.</p> <p>The resident's care plan revised 1/7/16 identified the resident required assistance with discharge planning and directed staff to encourage the resident to come to groups such as life skills, anger management, and stress relief to prepare him/her to live on his/her own and to remind the resident that his/her behaviors can affect his/her placement to certain facilities.</p>	F 223			

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F 223	<p>Continued From page 4</p> <p>Review of the clinical record revealed a Preadmission Screening and Resident Review (PASRR) letter dated 7/13/15 from the Kansas Department of Aging and Disability Services that indicated he/she had a CARE Level II assessment completed on 12/22/2001 and needed nursing facility level of care.</p> <p>Review of the physician ' s orders dated 8/21/15 revealed the resident was on the following medications: Ativan (for mood disorder), Zyprexa (for explosive personality), Geodon (for mood disorder), Trazadone (for insomnia), Ativan (for anxiety), and Ambien (for insomnia).</p> <p>A progress note dated 12/2/15 from consultant psychiatry staff JJ indicated the resident was stable and encouraged therapy attendance. The clinical record lacked evidence the resident was evaluated by a mental health nurse practitioner in July and September 2015.</p> <p>A nursing note dated 1/7/16 revealed staff overheard this resident yell "I am tired of people stealing from me!" and other residents reported to staff that this same resident hit a peer several times. This resident told staff "I got mad, I am sorry I hit him."</p> <p>Review of an investigation dated 1/7/16 revealed that another resident was sitting at a table at the end of the hallway by the vending machines. This resident approached the second resident and began to yell, call him/her names, and accused him/her of stealing. Review of the video surveillance revealed this resident hit the second resident in the chest approximately three times and choked him/her for approximately 10-15 seconds. The investigation concluded the argument between the two residents involved the dispute of a loan of one quarter.</p> <p>Review of the investigation indicated that administration was present in the facility at the</p>	F 223			

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F 223	<p>Continued From page 5</p> <p>time of the incident. The police were contacted per request of the second resident. No injuries were noted on the second resident and included documentation that the facility made notifications of both residents ' physicians and guardians. The police reviewed the video surveillance and counseled this resident on this behavior and in the future he/she could be arrested and charged with battery. The care plans were reviewed and updated.</p> <p>A nursing note dated 1/11/16 revealed the resident was in the nursing office speaking to staff with an increased tone and agitation and yelled "I have been locked up in these places for 20 years and you have to forgive these outbursts I have had!" The resident was placed on 15-minute staff observations.</p> <p>A nursing note dated 1/12/16 revealed the resident continued to have anger issues, yell at others, continued to complain about peers and staff. A fax regarding behaviors was sent to the consultant psychiatrist.</p> <p>An observation on 1/12/16 at 7:09 AM revealed he/she stood in the hallway near the dining room and displayed agitation behaviors of yelling at a female resident, making threats, and complaining about peers. The staff provided verbal redirection and continued the 15-minute staff observations on the resident per documentation on the behavior observation log.</p> <p>Review of the clinical record revealed this resident was placed on 15-minute staff observations during night shift on 1/11/16. The observation log documented the resident ' s location, mood and behaviors, and activities every 15 minutes of each shift.</p> <p>An interview on 1/12/16 at 2:45 PM with direct care staff Q revealed that licensed nursing staff would be notified immediately if the resident</p>	F 223			

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F 223	<p>Continued From page 6</p> <p>exhibited aggressive verbal or physical behaviors and stated the observation log is turned into licensed nursing staff at the end of the shift for review. Licensed staff J stated nursing reviewed the observation logs and then submit them to the director of nursing. Interview with administrative nursing staff D at this time revealed he/she reviews the observation logs and scans them into the clinical record. Administrative nursing staff D stated if aggressive behaviors are exhibited at any time, he/she expected to see documentation in the clinical record.</p> <p>An interview with the resident on 1/7/16 at 9:43 AM revealed he/she had a problem earlier in the morning and had been physical. The resident stated sometimes his/her " brain doesn ' t think right " and revealed he/she had become angry and hit another resident that had borrowed money. The resident stated " I wasn ' t thinking straight and I won ' t do it again. "</p> <p>An interview on 1/11/16 at 4:45 PM with administrative staff A revealed the staff would continue to educate this resident on how his/her behaviors impact others, and are currently monitoring behaviors and encouraging him /her to attend anger management classes.</p> <p>An interview on 1/11/16 at 5:15 PM with direct care staff P revealed that the resident ' s physical behavior was " out of character " and stated the staff have continued to monitor his/her behaviors and would report any increased agitation or yelling.</p> <p>An interview on 1/11/16 at 5:25 PM with licensed nursing staff I revealed the resident ' s display of aggressive physical behavior was " very unexpected " and as a precautionary measure the police had asked the resident to remain in his/her room until able to calm down. Licensed staff I stated that the measures in place to</p>	F 223			

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F 223	<p>Continued From page 7</p> <p>prevent further physical abuse by this resident included the monitoring of behaviors and general observations throughout each shift of his/her interactions with other residents. Staff I stated he/she would be alert to behaviors of increased agitation, yelling, and any mention of specific residents or aggravations.</p> <p>An interview on 1/12/16 at 7:12 AM with licensed nursing staff H indicated the incident on 1/7/16 was the first physical altercation this resident had since admission to the facility in July 2015 but that he/she had been involved in several verbal altercations with his/her most recent on this morning. Licensed nursing staff H stated to keep other residents safe, they have initiated the 15-minute staff observations and watching him/her for signs of agitation and stated " anything can and will set him/her off. "</p> <p>An interview on 1/12/16 at 7:20 AM with staff KK revealed that since he/she started at the facility in September 2015, he/she has held weekly group sessions on anger management and stress management and that out of a total of 15 sessions offered, this resident had attended one anger management group. Staff KK reviewed a hand written group attendance log and verified this resident ' s attendance at only one session. Staff KK stated the resident would greatly benefit from attending the group sessions based on his/her explosive personality and anger management issues, but that he/she cannot force the residents to attend group sessions. Staff KK stated the residents receive notification of group sessions, and is posted in five locations throughout the facility and that he/she does not make an announcement or provides personal invitations to the group sessions.</p> <p>A telephone interview on 1/13/16 at 9:50 AM with administrative staff A revealed that the facility had</p>	F 223			

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F 223	Continued From page 8 contacted the county attorney with a request to mandate anger management therapy for this resident. The facility provided an "Abuse, Neglect, and Exploitation" policy (no date). Review of the facility ' s policy included the resident had a right to be free from verbal and physical abuse and that the facility would take immediate actions to protect the resident. The facility failed to prevent the verbal and physical abuse of a resident by this resident with diagnoses of mood and personality disorders.	F 223			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. Based upon observation and interview, the facility failed to provide services to maintain a sanitary and comfortable interior of the facility for three of four days of onsite survey in the hall where residents resided.  Findings included:  - Observations noted during the survey starting on 01/06/15 at 9:35 A.M. and through 01/12/15 and during the environmental tour on 01/12/15 at 1:50 P.M. with maintenance supervisor X revealed the following:  The bathroom door frame was rusted and	F 253			

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F 253	Continued From page 9 corroded in 1 resident room.  The laminate on the sink counters was missing on the edge in 2 resident rooms.  The ceiling tiles in the main kitchen and in 1 resident room were water stained.  Interview on 01/12/2016 at 1:50 PM maintenance supervisor X stated he/she was unaware the laminate on the sinks was missing or the door jamb that was rusted. He/she stated the housekeeping staff were expected to identify and relay maintenance needs to him/her.  The facility failed to provide a policy about maintenance expectations as requested.  The facility failed to maintain a sanitary and comfortable environment.	F 253			
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441			

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F 441	<p>Continued From page 10</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: The facility identified a census of 35 residents. Based on observation, policy review, and interview, the facility failed to ensure facility staff provided a sanitary environment for residents when cleaning resident rooms. Findings included: - An observation on 1/12/16 at 8:43 AM revealed housekeeping staff Y cleaning a resident room. Staff Y donned gloves and emptied resident trash cans. Staff Y sprayed the sink, counter, and toilet with Hillyard Vindicator+ and stated it had a kill time of 10 minutes. Staff Y applied Vindicator+ to a cloth and immediately wiped the door knobs, sink and counter, hand rails in the bathroom, toilet paper holder and then proceeded to wipe</p>	F 441			

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F 441	<p>Continued From page 11</p> <p>the top of the toilet tank, and the outside of the toilet. Staff Y lifted the seat of the toilet and wiped it, wiped the bottom of the toilet and behind it, and cleaned the inside of the toilet with the cloth. Staff Y did not allow the Vindicator+ to sit for the required 10 minute kill time. Staff Y discarded the cloth, wiped his gloved hands with a paper towel, then sprayed the bathroom floor with Top Clean and mopped the bathroom floor. Staff Y continued to wear the same gloves and dry dusted the resident tables, televisions, radios, blinds, corners of the walls while moving resident shoes and blankets off of the floor and touching personal resident belongings on their tables as he/she dusted. Staff Y applied Vindicator+ to a clean cloth and wiped the table surfaces, then sprayed the room floor with Top Clean and mopped the floor. Staff Y removed his/her gloves and cleansed hands with alcohol hand gel prior to entering the next resident room.</p> <p>During an interview on 1/12/16 at 8:50 AM, Staff Y acknowledged that he/she should have changed gloves after cleaning the toilet and touching other surfaces and resident belongings. Staff Y stated he/she was not aware of a policy, procedure, or checklist for cleaning resident rooms.</p> <p>During an interview on 1/12/16 at 8:55 AM, Staff X stated the Hillyard Vindicator+ should be allowed to sit for 10 minutes for effective disinfecting.</p> <p>Review of the Hillyard Vindicator+ label and information sheet indicated the product is to remain wet on surfaces for 10 minutes to be an effective disinfectant.</p> <p>The facility provided an undated policy " Resident Room Daily Cleaning Procedures " which indicated " allow the surface you are cleaning to be wet with the disinfectant cleaner for at least 10</p>	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E591</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/19/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>VALLEY HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>400 12TH STREET PO BOX 189 VALLEY FALLS, KS 66088</b>		
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F 441	Continued From page 12 minutes. " The facility provided an undated policy " Hand Hygiene and Glove Usage " which indicated staff to remove gloves and sanitize hands prior to handling objects (drawers, call lights, etc.). The facility failed to clean resident rooms in a sanitary manner.	F 441		