

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607
--	--

(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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 80 residents</p>	F 157		

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: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 157	<p>Continued From page 1</p> <p>There were 18 residents in the sample. Based on observation interview and record review the facility failed to notify the physician of resident #22's significant weight loss in a timely manner.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #22's signed physician order sheet dated 12/4/2015 documented the following diagnoses: paranoid schizophrenia (a psychotic disorder characterized by gross distortion of reality), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and insomnia (an inability to sleep). <p>Review of the admission MDS (Minimum Data Set) dated 6/26/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident had hallucinations (seeing and/or hearing things, which were not real), delusions (an untrue persistent belief), and mild depression. The resident was independent with eating, weighed 184 pounds, was 75 inches tall, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period.</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 9/24/2015 documented a BIMS score of 15, which indicated intact cognition. The resident had hallucinations, delusions, and moderate depression. The resident was independent with</p>	F 157		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 157	<p>Continued From page 2</p> <p>eating with set up assistance from staff, weighed 170 pounds, was 75 inches tall, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 7/1/2015 documented the resident had delusions and hallucinations, paced the halls, and talked to unseen persons on invisible phones.</p> <p>The Nutritional CAA did not trigger for review.</p> <p>Review of the care plan dated 9/24/2015 documented the resident was happy with his/her current weight, wanted to maintain his/her weight, and notified staff if he/she changed his/her mind. The care plan directed staff to provide a double meat sandwich if requested, offer a room tray if he/she did not want to eat in the dining room, provide a regular diet, and assess his/her nutritional status once a year or if his/her condition changed, weight monthly and as needed, provide a snack every night before bed, and review nutrition quarterly. The care plan documented the resident slept much of the day, stayed up at night, and missed meals. He/she did not want staff to disturb him/her to ask about meals and would let staff know when he/she wanted to eat.</p> <p>The resident weighed 185 lbs (pounds) on 6/18/2015 and 170 lbs on 9/18/2015, which indicated a weight loss of 8.10% (percent) over 90 days. The resident weighed 166 lbs on 12/4/2015, which indicated a weight loss of 10.2% in less than 180 days.</p>	F 157			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 157	<p>Continued From page 3</p> <p>Review of a dietitian nutritional assessment dated 7/22/2015 documented the resident had a regular diet, fed himself/herself, and weighed 176.7 lbs. The resident lost 8.3 pounds since admission (4.5%) and chose not eat some meals. The resident's weight was appropriate, labs reflected adequate nutrition, and weight gain was not necessary. Recommendation was to continue to monitor for further weight loss and encourage sandwiches/foods during the day.</p> <p>Review of a physician order sheet dated 12/4/2015 included the following: Weigh monthly Regular Diet Fluoxetine (a medication used to treat depression, which may decrease appetite) 10 mg (milligrams) by mouth daily for depression</p> <p>During an observation on 12/09/2015 at 12:07 P.M. the resident sat at the dining room table and staff served him/her barbeque meatballs, green beans, cake, and juice. The resident ate 100% of meal independently and drank 75% of juice.</p> <p>During an observation on 12/10/2015 at 7:11 A.M. the resident sat at the dining room table and was served scrambled eggs, French toast sticks with syrup, 2 bowls of cereal with 2 cartons of milk, and sausage links. The resident ate 90% of French toast, 100% of eggs and drank both cartons of meal independently. The resident emptied the 2 bowls of cereal in the trash and left the dining room.</p> <p>During an interview on 12/09/2015 at 3:06 P.M. the resident said he/she lost 12 pounds in the past 2 months and he/she tried to eat more food. The resident said he/she had no appetite and did</p>	F 157			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 157	<p>Continued From page 4 not try to lose weight.</p> <p>During an interview on 12/09/2015 at 3:36 P.M. direct care staff Q said the resident stayed up late at night, slept a lot during the day, took staff multiple attempts to awaken for supper, and ate well when he/she came out for supper. Staff Q was not sure if the resident lost weight.</p> <p>During an interview on 12/10/2015 at 9 :59 A.M. direct care staff R said the resident was independent with eating. He/she said the resident did not always come out of breakfast, but usually came to the dining room for lunch and usually ate 100%. Staff R said he/she was not sure if the resident lost weight.</p> <p>During an interview on 12/14/2015 at 10:20 A.M. licensed nursing staff I said the resident was on a regular diet and lost 19 pounds since he/she admitted on June 18, 2015. Staff I said MDS Coordinators tracked weight loss and usually put residents on weekly weights and supplements. Staff I confirmed the resident was not weighed weekly, did not receive a nutritional supplement, and staff did not document meal intake. Staff I said the physician was not notified of the resident's weight loss.</p> <p>During an interview on 12/14/2015 at 2:24 P.M. administrative nursing staff E stated he/she was made aware the resident lost weight on 12/13/2015 by dietary staff. He/she confirmed the resident lost a significant amount of weight his/her first 90 days of admission and continued to lose a significant amount of weight. Staff E said he/she revised the resident's care plan on 9/8/2015 and directed staff to remind the resident he/she had sandwiches available upon request. Staff E said the physician was not notified in</p>	F 157			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 157	<p>Continued From page 5</p> <p>September of the significant weight loss.</p> <p>During an interview on 12/14/2015 at 9:30 A.M. dietary staff FF said he/she was not aware the resident lost a significant amount of weight and he/she was responsible for notifying the dietitian of weight loss.</p> <p>During an interview on 12/15/2015 at 10:55 A.M. administrative nursing staff D said he/she was not aware the resident lost a significant amount of weight, the facility overlooked the resident's weight loss, and staff made him/her aware of the weight loss of 12/14/2015. Staff D said he/she expected staff to notify the physician of the weight loss in September when a significant loss occurred</p> <p>During an interview on 12/15/2015 at 12:21 P.M. dietary consultant GG said he/she was not aware the resident lost a significant amount of weight until he/she received a call yesterday from the facility. Staff GG said he/she expected to notify him/her of the continued weight loss and said he/she would have seen the resident in September if the facility informed him/her of the weight loss.</p> <p>During an interview on 12/15/2015 at 10:05 A.M. physician consultant LL said the facility did not inform him/her of any weight loss since the resident admitted in June of 2015. Staff LL said he/she expected the facility to inform him/her of significant weight loss and said the resident's antidepressant medication, Fluoxetine, was an appetite depressant and may be a contributing factor to the resident's weight loss.</p> <p>Review of the facility's undated Notification of Change policy documented facility staff notified</p>	F 157			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 157	Continued From page 6 the physician of changes in condition and notification was recorded in the clinical record.	F 157		
F 159 SS=F	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to	F 159		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 159	<p>Continued From page 7</p> <p>the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 80 residents. Based on record review and interview, the facility failed to provide quarterly statements about the residents' funds accounts for 74 of 80 residents.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The Resident Trust Fund Authorization dated 8/17/11 for resident #71 indicated the resident would receive quarterly statements and when requested. <p>Interview on 12/08/15 at 10:25 A.M. resident #71 said he/she did not know how much money was in his/her personal funds account.</p> <p>Interview on 12/15/15 at 11:15 A.M. office staff II stated residents who have delegated the facility as their payee did not receive a quarterly statement. He/she confirmed 74 residents had delegated the facility as their payee.</p> <p>Interview on 12/15/15 at 11:20 A.M. administrative nursing staff D said residents with a personal funds account should be provided a quarterly statement.</p>	F 159		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 159	Continued From page 8 The facility policy "Personal Funds", undated, noted financial records would be provided quarterly. The facility failed to provide quarterly statements about the residents' funds accounts.	F 159		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This Requirement is not met as evidenced by: The facility identified a census of 80 residents. Based on record review and interview, the facility failed to release a resident's funds within 30 days of death for one (#87) of 2 residents reviewed. Findings included: - Review of resident #87's accounting log revealed a check written on 2/27/15. Interview on 12/15/15 at 11:10 A.M. business office manager II stated the resident died on 1/21/15. The facility failed to provide a policy about the release of resident funds after death. The facility failed to release funds within the required 30 days after death for this resident.	F 160		
F 223	483.13(b), 483.13(c)(1)(i) FREE FROM	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223 SS=F	<p>Continued From page 9</p> <p>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 reported a census of 80 residents. There were 18 residents in the sample. Based on observation, interview, and record review the facility failed to protect 9 sampled residents and 1 unsampled resident from verbal and physical abuse by failure to follow facility developed corrective actions when verbal and physical abuse occurred. (#6, #11, #25, #29, #30, #35, #73, #75, #84, and 1 unsampled resident).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #30's signed physician order sheet dated 12/4/2015 documented the following diagnoses: bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships), depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and mild intellectual disorders (a learning disability). <p>Review of the annual MDS (Minimum Data Set) dated 6/18/2015 documented a BIMS (Brief Interview for Mental Status) score of 12, which</p>	F 223		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 10</p> <p>indicated moderate cognitive impairment. The resident had delusions, verbal aggression directed towards others, and did not reject cares. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the quarterly MDS dated 9/17/2015 documented a BIMS score of 12, which indicated moderate cognitive impairment. The resident had delusions, verbal aggression and other behaviors directed towards others, and he/she rejected cares for 1-3 of 7 days. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the Cognitive CAA (Care Area Assessment) dated 6/19/2015 documented the resident had inattentiveness, disorganized thinking, and delusions.</p> <p>Review of the Mood and Behavior CAA dated 6/19/2015 documented the resident had bipolar disorder, borderline personality disorder, mild intellectual disability, and depression and took medications to treat the disorders.</p> <p>Review of the care plan dated 11/7/2015 documented the resident sought staff attention and reassurance and had difficulty managing his/her frustration. The resident paced and had inappropriate responses to verbal communication, displayed violent/aggressive behavior towards staff and other residents, and was aggressive at times when he/she had increased anxiety. The care plan directed staff to be patient and calm in response to anger and frustration and assist the resident with coping strategies to include; talking, breathing exercises,</p>	F 223			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 11</p> <p>walking, an remind the resident of appropriate ways to handle his/her anger.</p> <p>Review of an incident investigation documented on 7/18/2015 at 5:12 P.M. the resident became agitated and began yelling in the dining room, which caused resident #84 to yell back. The resident hit resident #84 on the head and resident #84 kicked the resident on his/her arm and leg. The facility reported corrective action taken included; immediate separation and assessment, police notified, increased visual monitoring and staff presence while signs and symptoms of anxiety and aggression were present, staff administered an as needed medication for anxiety and aggression, and the social worker spoke with the resident to ensure physical and emotional well-being and discussed non-violent ways to handle stressful situations.</p> <p>Review of nursing progress notes dated 7/18/2015 lacked documentation of the altercation that occurred on 7/18/2015.</p> <p>Review of the MAR (Medication Administration Record) dated 7/18/2015 lacked documentation staff administered an as needed medication for anxiety and aggression.</p> <p>Review of social service notes dated 7/18/2015 through 7/20/2015 lacked documentation of the altercations which occurred on 7/18/2015 and lacked discussion between social services and the resident regarding physical and emotional well-being and ways to handle stressful situations.</p> <p>Review of an incident investigation documented on 10/18/2015 at 5:00 P.M. the resident and resident #77 were in the dining room and argued</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 12</p> <p>over seating. Resident #77 hit the resident in his/her face twice, which caused swelling to his/her right eye. The facility reported corrective actions taken by the facility included; immediate separation and assessment, police notified, increased visual monitoring when in the same areas of the building and signs/symptoms of anxiety and aggression were present, staff administered an as needed medication for pain, physician notified of incident, social worker met with the residents and discussed dining room choices, and dining room rules and etiquette were discussed in the October Resident Council Meeting.</p> <p>Review of nursing progress notes dated 10/18/2015 lacked documentation of the altercation and physician notification of the altercation that occurred on 10/18/2015.</p> <p>Review of the MAR dated 10/18/2015 lacked documentation of staff administered an as needed medication for pain.</p> <p>Review of social service notes dated 10/18/2015 through 10/19/2015 lacked documentation of social service meeting with the resident to discuss dining room choices.</p> <p>Review of October 2015 resident council minutes lacked discussion of dining room rules and etiquette.</p> <p>Review of physician orders dated 10/21/2015 documented an order for an X-ray to the resident's right eye to rule out fracture due to pain. No blowout fracture seen on X-ray dated 10/21/2015.</p> <p>During an observation on 12/09/2015 at 12:12</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 13</p> <p>P.M. the resident sat at the dining room table and interacted appropriately with tablemates and staff.</p> <p>During an observation on 12/09/2015 at 2:58 P.M. the resident sat at the dining room table alone. He/she was alert, smiled, and interacted with staff and resident as they passed his/her table.</p> <p>During an interview on 12/09/2015 at 2:54 P.M. the resident said there were always fights going on in the dining room. He/she said residents did not like him/her and he/she did not know why. The resident said he/she tells staff when resident #84 threatens him/her and staff do not care.</p> <p>During an interview on 12/09/2015 at 3:38 P.M. direct care staff Q said the resident and resident #84 did not get along and were verbally and physically abusive towards each other. Staff Q said verbal and physical altercations happen often in the dining room and he/she did not report unless actual physical harm occurred.</p> <p>During an interview on 12/10/2015 at 10:02 A.M. direct care staff R said he/she witnessed resident #84 reach out to strike other resident, but did not report to his/her charge nurse or administration because he/she did not actual hit another resident.</p> <p>During an interview on 12/14/2015 at 8:22 A.M. direct care staff S said the resident and resident #84 had numerous verbal and physical altercations in the past and he/she witnessed resident #84 hit the resident many times. Staff S said he/she heard of an incident when resident #77 hit the resident and the resident got a black eye. Staff S said he/she would let the nurse know of altercations if a resident got hit or hurt.</p> <p>During an interview on 12/14/2015 at 10:41 A.M.</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 14</p> <p>licensed nursing staff I said he/she was not aware of any physical altercations between the resident and other residents. Staff I said he/she was told of incidents usually through hearsay and sometimes in report, "but not always". Staff I said he/she believed altercations between resident were not communicated appropriately and he/she often heard of resident altercations weeks after altercations occurred.</p> <p>During an interview on 12/15/2015 at 10:19 A.M. licensed nursing staff K said if a resident altercation occurred which had the potential for harm or caused harm he/she would notify the nursing administrator either by phone call or an email and only documented resident to resident altercations in the clinical record if administration told him/her to document.</p> <p>During an interview on 12/14/2015 at 11:41 A.M. social service staff JJ said he/she did not document follow up on the verbal and physical altercation that occurred between the resident and resident #84 according to the facility developed corrective action plan because the altercation was verbal and no one was hurt. Staff JJ said he/she did not document follow up on the verbal and physical altercations between the resident and resident #77 because resident #77 bullied others, the facility had difficult times with him/her, and the facility had already intervened. Staff JJ said he/she did not complete the corrective action interventions and was not always made aware of the facility developed corrective plan interventions.</p> <p>During an interview on 12/15/2015 at 10:38 A.M. administrative nursing staff D said he/she expected staff to report all resident to resident altercations to the immediate supervisor and the immediate supervisor was expected to report the altercation to the administrator. Staff D said</p>	F 223			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 15</p> <p>he/she expected staff to follow the corrective action plan developed following an altercation and expected follow up and resident response to be documented in the clinical record. Staff D said he/she expected the nurses on duty to documentation resident to resident altercations in the clinical record and administer as needed medications as indicated. Staff D said increased visual monitoring consisted of staff being more present in the area. He/she confirmed staff did not document increased visual monitoring and he/she understood the importance of monitoring and documenting the results and effectiveness of increased visual monitoring.</p> <p>During an interview on 12/09/2015 at 4:14 P.M. administrative staff A said he/she did not expect staff to inform him/her of an resident to resident altercations unless a resident was hit or got hurt.</p> <p>Review of the facility's undated Abuse, Neglect, and Exploitation policy documented residents had the right to be free from abuse and the facility took immediate action to protect the residents.</p> <p>The facility failed to follow through on facility developed corrective action interventions and protect resident #30 from verbal and physical abuse on 2 occasions of resident to resident altercations.</p> <p>- Review of resident's #6's quarterly Minimum Data Set dated 11/5/15 included the resident scored 7 (severely impaired cognition) on the Brief Interview for Mental Status, had hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 16</p> <p>untrue), displayed verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others 4 to 6 days but less than daily during the 7 day assessment period and ambulated independently in the room/corridor.</p> <p>The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/31/14 included the resident had diagnoses of Schizoaffective Disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) which could affect his/her cognition.</p> <p>The resident's Activity of Daily Living CAA dated 12/31/14 included the resident ambulated independently.</p> <p>The resident's Behavioral Symptoms CAA dated 12/31/14 included the resident was physically agitated at times, paced and made physical gestures or was sexually inappropriate. The resident also exhibited verbal outbursts, such as yelling (either when really excited or upset), had rapid speech, or responded inappropriately to questions. The resident's behaviors was difficult to redirect at times and staff currently monitored the resident for physical agitation.</p> <p>Review of the resident's Level II PASAAR (Preadmission Screening and Resident Review) dated 6/17/1995 documented the following recommendations: Community based mental health services to monitor mental health needs. Psychiatrist to monitor the mental health illness</p>	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 17 and psychiatric medications.</p> <p>Review of the resident's clinical record lacked evidence the resident received community based mental health services to monitor his/her mental health needs.</p> <p>A psychiatrist treatment note dated 11/5/15 documented the resident continued to have problems which was mostly violent behavior toward others and being disruptive.</p> <p>A physician progress note dated 11/30/15 documented the resident was chronically ill with agitated demeanor. The resident did not appear stable from mental standpoint, and the resident apparently had outbursts again which were a problem.</p> <p>Review of a complaint investigation included that on 1/10/15 at approximately 4:30 P.M. resident #29 was in the dining room and spoke to unseen others. Resident #6 was near by and thought resident #29 was speaking to him/her and got agitated and began arguing with the resident. Staff heard the arguing and rushed to the location but before they were able to intervene resident #6 reached out and hit resident #29 in his/her back.</p> <p>The investigation included the facility implemented the following corrective actions: staff separated the residents and initiated assessments, notified local law enforcement and neither resident filed charges. Staff increased visual monitoring for both residents when the residents exhibited signs/symptoms of anxiety and aggression. Both residents were offered and administered as needed medications for agitation/anxiety. The social worker met with both residents and discussed non-violent ways to</p>	F 223			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 18</p> <p>handle stressful situations which could result in acts of aggression.</p> <p>The investigation summary included staff regularly monitored the interventions and adjusted them as needed to minimize the chance of a situation like this happening in the future.</p> <p>The resident's clinical record did not have any reference to the incident or to any specific medication staff administered.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed with the residents non-violent ways to handle stressful situations which could result in acts of aggression.</p> <p>Resident's #75 clinical record identified the resident was deaf (unable to hear) and had mild intellectual difficulties.</p> <p>The resident's (resident #75) annual Minimum Data Set (MDS) identified the resident had moderately impaired cognition.</p> <p>Review of a complaint investigation documented on 9/8/15 at approximately 11:45 A.M. the resident became agitated and believed that his/her roommate, resident #75 was talking about him/her. The resident hit resident #75 on the side of his/her head. Staff was near by and immediately intervened by separating the residents and redirected resident #75 away from the area. Resident #6 remained in his/her room and swore and acted aggressive toward staff at which time staff offered and administered the resident an as needed medication for for</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 19 agitation/anxiety.</p> <p>The investigation included the facility implemented the following interventions. Staff separated the residents and assessments revealed neither of the residents were injured. Staff notified local law enforcement of the incident and no report was filled. Staff increased visual monitoring and staff presence for resident #6 when he/she exhibited signs/symptoms of anxiety and aggression. The social worker met with resident #6 and discussed the situation and appropriate ways to handle himself/herself if he/she felt anxious or upset. A room change was arranged and agreed upon by both individuals. Resident #6's medications were evaluated with changes made as physician ordered.</p> <p>The investigation summary included staff regularly monitored the interventions and adjusted them as needed to minimize the chance of a situation like this from occurring again.</p> <p>The residents' clinical records did not reference the incident.</p> <p>Review of the residents' clinical records lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed with resident #6 appropriate ways to handle himself/herself when he/she felt anxious or upset.</p> <p>Review of a complaint investigation documented on 12/3/15 at approximately 3:30 A.M. resident #6 and resident #73 got into an argument near the nurses station. The charge nurse attempted to separate the residents but resident #6 hit the charge nurse on the side of his/her face and</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 20</p> <p>pushed resident # 73 which caused the resident to fall to the ground. Resident #73 got himself/herself off of the floor and hollered at resident #6 and staff redirected resident #73 to a chair and redirected resident #6 to his/her room. Resident #6 told staff resident #73 was talking about him/her which caused him/her to become irritated.</p> <p>The investigation included the facility implemented the following corrective actions:staff immediately intervened and separated the residents/ Assessments were initiated and no injuries were observed. Staff notified local law enforcement of the incident and no charges were filed.</p> <p>Staff offered and administered resident #6 an as needed medication. Staff increased visual monitoring for both residents when the residents exhibited signs/symptoms of agitation.</p> <p>The investigation summary included staff regularly monitored the interventions and adjusted them as needed to minimize the chance of a situation like this form occurring again.</p> <p>On 12/8/15 at approximately 10:05 A.M. a surveyor received permission from the resident to enter his/her room for a resident interview. Observation revealed resident #6 and resident #75 were roommates. During the interview the resident demanded the surveyor look at a photo album and the surveyor explained to the resident he/she would after the interview. The resident became upset, yelled at the surveyor and attempted to hit the surveyor in the head with the album. Staff immediately came to the resident's room and redirected the resident.</p> <p>On 12/9/15 at 8:05 A.M. the resident was in the</p>	F 223			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 21</p> <p>dining room yelling and nursing administrative staff D stated the resident hit him/her. Staff redirected the resident and the resident yelled at staff to get his/her hands off of him/her.</p> <p>On 12/14/15 at approximately 7:10 A.M. the resident exited his/her room, spoke to the surveyors and ambulated independently to the dining room. As the resident reached the entrance to the dining room the resident yelled an expletive. Staff escorted the resident to his/her room and the resident yelled get your hands off of him/her.</p> <p>On 12/9/15 at approximately 5:15 P.M. administrative nursing staff D stated the resident did not receive outside mental health services because the agencies that offered the service was not able to bill for mental health services when residents resided in a nursing facility.</p> <p>On 12/9/15 at 3:00 P.M. staff KK confirmed resident #6 and resident #75 were roommates. He/she stated both residents became upset when staff attempted the room change so staff allowed the residents to remain in the same room.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 22</p> <p>actions. Staff JJ stated he/she would not have documented anything regarding this incident because neither resident sustained injuries and staff immediately intervened.</p> <p>The facility's undated Abuse, Neglect and Exploitation Policy and Procedure included the facility ensured residents were free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation and injuries of unknown origins. The facility took immediate actions to protect the resident. All occurrences were analyzed to determine what changes were needed, if any, to policies and procedures to prevent further occurrences.</p> <p>The facility failed to have systems in place to ensure all staff were informed of corrective actions implemented after resident to resident abuse. The facility also failed to ensure corrective actions were implemented and monitored. The facility also failed to ensure this resident received mental health services as recommended. This practice failed to ensure all residents were protected from this resident with a history of violent and aggressive behaviors.</p> <p>Resident #35's electronic medical record included the resident had diagnoses that included Bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) , Cerebral Palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), Depressive Disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) and a history of falls.</p>	F 223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	Continued From page 23 The resident's annual Minimum Data Set dated 10/29/15 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had hallucinations, delusions, displayed verbal behavioral symptoms toward others, and other behavioral symptoms not directed toward others 4 to 6 days, but less than daily during the 7 day assessment period. The resident required extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, dressing, toilet use, and personal hygiene and the activity of walking in the room/corridor did not occur. The resident received an antipsychotic and an antidepressant medication 7 of the 7 days during the assessment period. The resident's care plan dated 11/5/15 included staff monitored the resident's behavior for restlessness, hallucinations, yelling and delusions. Review of a complaint investigation with an incident date of 11/19/15 documented that at approximately 1:30 A.M. this resident (#35) and an unsampled residential health care resident (RHC) got into an argument in the dining room because the RHC resident thought resident #35 called him/her names. The RHC resident pushed resident #35's head and kicked his/her chair. Staff was nearby and separated the residents. The investigation included the facility implemented the following corrective actions: Staff immediately separated the residents and assessments revealed both residents were free from injury. The facility increased staff presence while the residents were in the same areas of the building and exhibited signs/symptoms of anxiety and aggression. The social worker discussed	F 223		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 24</p> <p>with both residents non-violent ways to handle stressful situations which could result in acts of aggression/violence. Staff was counseled on proper ways to communicate with resident #35 when he/she experienced delusions. The RHC resident was taken to a local hospital for a psychiatric evaluation and he/she later returned to the facility per his/her request.</p> <p>The resident's clinical record did not have any reference to the incident.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed with the residents non-violent ways to handle stressful situations. There was also no evidence to support the social worker counseled staff on proper way to communicate with resident #35 when he/she experienced delusion. There was also no evidence to support the RHC resident had a psychiatric evaluation.</p> <p>On 12/10/15 at 8:15 A.M. the RHC resident ambulated independently in the facility.</p> <p>On 12/10/15 at 2:30 P.M. resident #35 self-propelled his/her wheelchair in the hallways.</p> <p>On 12/10/15 at 1:30 P.M. resident #35 propelled his/her wheelchair down the RHC hall.</p> <p>During Stage 1 of the survey resident #35 reported to a surveyor that approximately a month ago a resident hit him/her and staff was aware of the incident. Resident #35 provided the name of the resident to the surveyor.</p>	F 223			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 25</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she was aware of the incident. Staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. Staff JJ stated he/she could not recall the incident and after reviewing the investigation, he/she stated since the RHC resident received outside interventions, nursing staff would have documented on the corrective actions.</p> <p>On 12/15/15 at approximately 3:30 P.M. administrative nursing staff D stated the RHC resident did not receive the psychiatric evaluation as planned.</p> <p>The facility's undated Abuse, Neglect and Exploitation Policy and Procedure included the facility ensured residents were free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation and injuries of unknown origins. The facility took immediate actions to protect the resident. All occurrences were analyzed to determine what changes were needed, if any, to policies and procedures to prevent further occurrences.</p> <p>The facility failed to have systems in place to ensure all staff were informed of corrective actions implemented after resident to resident</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 26</p> <p>abuse. The facility also failed to have systems in place to ensure corrective actions were implemented and monitored.</p> <p>- Review of a complaint investigation with an incident date of 9/6/15 included on 9/6/15 at approximately 4:30 P.M. resident #25 was in the dining room and became agitated. An unsampled Resident Health Care Facility Resident (RHC) told resident #25 to be quiet which started an argument between the two. The RHC resident walked over to where resident #25 sat and pushed the resident in the head. Staff was near-by and immediately intervened and separated the residents.</p> <p>The investigation included the facility implemented the following corrective actions: Staff immediately intervened and separated the residents. Assessments were initiated and no injuries were noted. The facility notified local law enforcement and neither resident wanted to file charges. Staff increased visual monitoring and staff presence when the residents were in the same area of the building and when showing signs/symptoms of agitation and anxiety. Staff offered and administered resident #25 and as needed medication for agitation/anxiety and the facility requested a medication evaluation for both residents. The social worker followed up with both residents to regarding his/her emotional well-being and educated the residents on ways to handle himself/herself in times of increased stress.</p> <p>The resident's clinical record did not have an reference to the incident.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 27</p> <p>presence when the residents were in the same areas and also lacked evidence to support the social worker educated the residents on ways to handle himself/herself in times of increased stress. There was also no evidence to support the facility requested medication evaluations for the residents as planned.</p> <p>On 12/10/15 at 8:15 A.M. the RHC resident ambulated independently in the facility.</p> <p>On 12/10/15 at 12:30 resident #25 sat at a dining room table.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. Staff JJ stated he/she would not have documented anything regarding this incident because neither resident sustained injuries and staff immediately intervened. .</p> <p>The facility's undated Abuse, Neglect and Exploitation Policy and Procedure included the facility ensured residents were free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation and injuries of unknown origins. The facility took immediate actions to protect the resident. All occurrences were analyzed to</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 28</p> <p>determine what changes were needed, if any, to policies and procedures to prevent further occurrences.</p> <p>The facility failed to have systems in place to ensure all staff were informed of corrective actions implemented after resident to resident abuse. The facility also failed to have systems in place to ensure corrective actions were implemented and monitored.</p> <p>- Review of a complaint investigation revealed that on 6/5/15 at approximately 10:20 A.M. resident #25 and resident #84 got into altercation on the back patio of facility. Resident #25 spoke with a staff regarding he/she was not going to take his/her medications until after he/she smoked. Resident #84 told resident #25 to shut up, resident #25 responded by yelling at resident #84 and told him/her to mind his/her own business. Resident #84 then walked over and threw his/her soda on resident #25. As retaliation resident #25 threw his/her cup of water on resident #84 and the residents grabbed at the other's clothes and hair. Resident #25 pulled resident's #84's hair and resident #84 hit resident #25 in the groin and the staff intervened and stopped the altercation.</p> <p>The investigation included the facility implemented the following corrective actions. Staff immediately separated the residents and staff initiated assessments. Staff increased visual monitoring when the resident exhibited signs/symptoms of anxiety and aggression and increased staff presence when the residents were in the same area of the building and exhibited signs/symptoms of anxiety and aggression. Staff contacted local law enforcement and no charges were pressed by either party. Both resident were</p>	F 223			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 29</p> <p>offered as needed medications for pain and anxiety. The social worker would discuss non-violent ways to handle stressful situations which could result in acts of aggression. The social worker followed up with the residents to ensure his/her physical and emotional well-being. Resident #84 was counseled on appropriate ways to address his/her peers that would not lead to an altercation.</p> <p>The residents clinical record did not have an reference to the incident.</p> <p>Review of the residents clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker educated the residents on non-violent ways to handle himself/herself in stressful situations and/or followed up with the residents as planned.</p> <p>Review of a complaint investigation revealed on 8/24/15 at approximately 1:15 A.M. resident #25 and resident #77 got into a verbal altercation in the dining room. Staff intervened and redirected resident #77 away from the area at which point resident #84 hollered at resident #25 and stated he/she was going to beat him/her. Resident #84 walked over to resident #25 and hit him/her on the side of his/her head. Staff immediately separated the residents and and notified the charge nurse.</p> <p>The investigation included the facility took the following corrective actions: Staff immediately intervened and separated the residents. Staff initiated assessments and no injuries were noted. Staff notified local law enforcement of the incident and no charges were filed. Staff increased visual</p>	F 223			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 30</p> <p>monitoring and staff presence when the residents exhibited signs/symptoms of anxiety and aggression. Both residents were offered and administered as needed medications for agitation/anxiety. The social worker met with the resident to ensure the residents physical and emotional well-being and to discuss non-violent ways to handle stressful situations.</p> <p>The resident ' s clinical record did not have an reference to the incident.</p> <p>Review of the resident ' s clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker educated the residents on non-violent ways to handle himself/herself in stressful situations and/or followed up with the residents as planned.</p> <p>Review of a complaint investigation documented on 10/14/15 at approximately 4:10 P.M. resident #84 walked to the dining room and demanded that resident #11 move out of the chair where he/she sat so he/she could have it, resident #11 responded "no" and told resident #84 that he/she would need to find somewhere else to sit. The residents argued and before staff could intervene resident #84 kicked at resident while he/she was sitting down, in return resident #11 kicked resident #84 which caused him/her to fall back on the ground. Resident #84 got himself/herself up off of the floor, hollered at resident #11 and called the resident names.</p> <p>The investigation included the facility implemented the following corrective actions: staff immediately separated the residents and initiated assessments and no injuries were</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	<p>Continued From page 31</p> <p>observed. Staff notified local law enforcement, law enforcement spoke with the residents and no report was filed. Staff increased visual monitoring for both residents when the residents exhibited signs/symptoms of anxiety and aggression. Both residents were offered as needed medications for agitation/anxiety which they refused. The social worker met with both residents and discussed socially appropriate behaviors and how to handle himself/herself in stressful situations.</p> <p>Review of the residents' clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed socially appropriate behaviors and how to handle himself/herself in stressful situations.</p> <p>On 12/10/15 at 12:30 resident #84 sat at a dining room table.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. Staff JJ stated he/she would not have documented anything regarding this incident because neither resident sustained injuries and staff immediately intervened. .</p>	F 223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 223	Continued From page 32 The facility's undated Abuse, Neglect and Exploitation Policy and Procedure included the facility ensured residents were free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation and injuries of unknown origins. The facility took immediate actions to protect the resident. All occurrences were analyzed to determine what changes were needed, if any, to policies and procedures to prevent further occurrences. The facility failed to have systems in place to ensure all staff were informed of corrective actions implemented after resident to resident abuse. The facility also failed to have systems in place to ensure corrective actions were implemented and monitored to prevent further occurrences from happening.	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 225	<p>Continued From page 33</p> <p>to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This Requirement is not met as evidenced by: - On 12/8/15 at 2:47 P.M. resident #25 sat at a dining room table. The resident stated a couple of days ago a resident picked up a pool ball, threw the pool ball at him/her and the ball struck him/her. The resident stated he/she threw the pool ball back at the resident, the resident ducked, the pool ball hit and broke the the patio window and the facility told him/her that he/she had to pay for the window. The resident gave the gender of the resident but did not know the resident's name.</p> <p>On 12/9/15 at 7:15 A.M. the resident sat at a dining room table and spoke to administrative staff A about the incident. The resident informed administrative staff A it was his/her "constitutional right" to self defend himself/herself. Administrative staff A told the resident he/she should have reported the incident to the nurse rather than throwing the pool ball.</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 225	<p>Continued From page 34</p> <p>The resident's clinical record lacked any reference of the incident.</p> <p>On 12/9/15 at 1:45 P.M. staff KK stated resident #25 and another resident had an altercation, resident #25 threw a pool ball at the resident, the ball missed the resident and broke the window. He/she stated the facility did not do an investigation nor did the facility report the incident to the Sate Survey Agency because the pool ball did not hit the resident.</p> <p>The facility's undated Abuse, Neglect and Exploitation Policy and Procedure included any allegation of abuse, neglect or exploitation, ... must be immediately reported to a Supervisor and/or the Administrator. The Administrator or his/her designee reported the occurrence to local and state agencies.</p> <p>The facility failed to investigate and report to the Sate Survey Agency an allegation of resident to resident abuse.</p> <p>- Review of resident #30's signed physician order sheet dated 12/4/2015 documented the following diagnoses: bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships), depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and mild intellectual disorders (a learning disability).</p> <p>Review of the annual MDS (Minimum Data Set) dated 6/18/2015 documented a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderate cognitive impairment. The</p>	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 225	<p>Continued From page 35</p> <p>resident had delusions, verbal aggression directed towards others, and did not reject cares. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the quarterly MDS dated 9/17/2015 documented a BIMS score of 12, which indicated moderate cognitive impairment. The resident had delusions, verbal aggression and other behaviors directed towards others, and he/she rejected cares for 1-3 of 7 days. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the Cognitive CAA (Care Area Assessment) dated 6/19/2015 documented the resident had inattentiveness, disorganized thinking, and delusions.</p> <p>Review of the Mood and Behavior CAA dated 6/19/2015 documented the resident had bipolar disorder, borderline personality disorder, mild intellectual disability, and depression and took medications to treat the disorders.</p> <p>Review of the care plan dated 11/7/2015 documented the resident sought staff attention and reassurance and had difficulty managing his/her frustration. The resident paced and had inappropriate responses to verbal communication, displayed violent/aggressive behavior towards staff and other residents, and was aggressive at times when he/she had increased anxiety. The care plan directed staff to be patient and calm in response to anger and frustration and assist the resident with coping strategies to include; talking, breathing exercises, walking, and remind the resident of appropriate</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 225	<p>Continued From page 36 ways to handle his/her anger.</p> <p>Review of nursing notes dated 9/1/2015 through 12/8/2015 lacked documentation of an altercation between the resident and resident #84.</p> <p>During an observation on 12/09/2015 at 12:12 P.M. the resident sat at the dining room table and interacted appropriately with tablemates and staff.</p> <p>During an observation on 12/09/2015 at 2:58 P.M. the resident sat at the dining room table alone. He/she was alert, smiled, and interacted with residents and staff as they passed by his/her table.</p> <p>During an interview on 12/09/2015 at 2:54 P.M. the resident said a couple of months ago resident #84 tried to hit him/her with a pool stick, threatened him/her, and yelled at him/her. The resident said staff were present during the altercation, did not intervene, and he/she told administrative staff.</p> <p>During an interview on 12/09/2015 at 3:38 P.M. direct care staff Q said the resident and resident #84 did not get along and were verbally and physically abusive towards each other. Staff Q said verbal and physical altercations happened often in the dining room and he/she did not report unless actual physical harm occurred. Staff Q said he/she heard resident #84 tried to hit the resident with a pool stick in the recent past and was not sure who told him/her. Staff Q said he/she did not report the incident to a charge nurse or administration.</p> <p>During an interview on 12/10/2015 at 10:02 A.M. direct care staff R said he/she heard about an incident between the resident and resident #84</p>	F 225			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 225	<p>Continued From page 37</p> <p>involving a pool stick, did not witness the incident, and did not report the incident to a charge nurse or administration.</p> <p>During an interview on 12/14/2015 at 8:22 A.M. direct care staff S said direct care staff T told him/her about an incident between the resident and resident #84 involving a pool stick, which occurred a couple of weeks ago. Staff T said he/she did not report the incident to administration because he/she thought administration already knew. Staff S said the resident and resident #84 had numerous verbal and physical altercations in the past and he/she witnessed resident #84 hit the resident many times. Staff S he/she let the nurse know of altercations if a resident got hit or hurt.</p> <p>During an interview on 12/14/2015 at 8:22 A.M. direct care staff S said direct care staff T told him/her about an incident between the resident and resident #84 involving a pool stick, which occurred a couple of weeks ago. Staff T said he/she did not report the incident to administration because he/she thought administration already knew. Staff S said the resident and resident #84 had numerous verbal and physical altercations in the past and he/she witnessed resident #84 hit the resident many times. Staff S stated he/she would let the nurse know of altercations if a resident got hit or hurt.</p> <p>During an interview on 12/14/2015 at 10:41 A.M. licensed nursing staff I said he/she was not aware of an incident between the resident, resident #84, and a pool stick. Staff I said he/she was told of incidents usually through hearsay and sometimes in report, "but not always". Staff I said he/she believed altercations between resident were not communicated appropriately and he/she often heard of resident altercations weeks after</p>	F 225			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 225	<p>Continued From page 38 altercations occurred.</p> <p>During an interview on 12/15/2015 at 10:19 A.M. licensed nursing staff K said he/she was not aware of an altercation involving the resident, resident #84, and a pool stick. Staff K said if a resident altercation occurred, which had the potential for harm or caused harm he/she notified the nursing administrator either by phone or an email and only documented resident to resident altercations in the clinical record if administration told him/her to document.</p> <p>During an interview on 12/15/2015 at 10:38 A.M. administrative nursing staff D said he/she was not aware of an altercation occurring between the resident, resident #84, and a pool stick. Staff D expected staff to report all resident to resident altercations to the immediate supervisor and the immediate supervisor was expected to report the altercation to the administrator.</p> <p>During an interview on 12/09/2015 at 4:14 P.M. administrative staff A said the resident did not tell him/her about an incident involving the resident, resident #84, and a pool stick. Staff A said he/she knew the residents did not get along and staff tried to keep the residents separated.</p> <p>During an interview on 12/14/2015 at 9:41 A.M. administrative staff KK said he/she completed incident reports involving resident to resident altercations and he/she was not aware of an incident between the resident, resident #84, and a pool stick.</p> <p>Review of the facility's undated Abuse, Neglect, and Exploitation policy documented the facility ensure residents had the right to be free from verbal, sexual, mental, and physical abuse and</p>	F 225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 225	Continued From page 39 staff immediately reported allegations of abuse to the immediate supervisor and/or the administration. The facility fail to investigate a verbal and physically threatening altercation between this resident and resident #84 who had previous verbal and physical altercations in the past.	F 225		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This Requirement is not met as evidenced by: The facility reported a census of 80 residents. There were 18 residents in the sample. Based on observation, interview, and record review the facility failed to assess bathing preferences for 1 of 3 residents reviewed for choices. (#54) Findings included: - Review of resident #54's signed physician order sheet dated 12/4/2015 documented the following diagnosis: Parkinsonism (a slow progressive neurological disorder characterized by resting tremor, rolling of the fingers, mask-like faces, shuffling gait, muscle rigidity and weakness). Review of the quarterly MDS (Minimum Data Set) dated 8/27/2015 documented a BIMS score of 15, which indicated intact cognition. The resident reported it was very important to him/her to	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 242	<p>Continued From page 40</p> <p>choose between a tub bath, shower, bed bath, or sponge bath, required supervision and set up with bathing, and did not reject cares.</p> <p>Review of the annual MDS dated 11/24/2015 documented a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The resident reported it was very important to him/her to choose between a tub bath, shower, bed bath, or sponge bath, and required supervision and set up assistance with bathing.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 11/25/2015 documented the resident was alert and oriented, exhibited fluctuating inattentiveness and disorganized thinking.</p> <p>Review of the ADL (activities of daily living) CAA dated 11/25/2015 documented the resident was independent with most ADL and needed occasional reminders/encouragement and set up assistance with hygiene and showering tasks.</p> <p>Review of the care plan dated 11/25/2015 documented the resident preferred to take 3 showers a week in the mornings.</p> <p>During an observation on 12/09/2015 at 3:05 P.M. the resident ambulated in the dining room. He/she wore clean clothes and had clean skin.</p> <p>During an observation on 12/15/2015 at 7:38 A.M. the resident laid in bed with eyes closed.</p> <p>During an interview on 12/09/2015 at 3:04 P.M. the resident said he/she showered every Tuesday, Thursday, and Saturday and preferred to receive a tub bath. The resident said staff</p>	F 242			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 242	<p>Continued From page 41</p> <p>never asked about his/her bathing preference.</p> <p>During an interview on 12/09/2015 at 3:49 P.M. direct care staff Q said staff asked residents bathing preference on admission and was not sure of the resident's bathing preference.</p> <p>During an interview on 12/10/2015 at 10:12 A.M. direct care staff R said direct care staff asked residents bathing preferences on admission and sometimes the nurse asked. He/she was not aware of the resident's bathing preference.</p> <p>During an interview on 12/14/2015 at 11:02 A.M. licensed nursing staff I said staff asked residents bathing preferences on admission and every 90 days. Staff I reviewed the resident's clinical record and said the record lacked a preference assessment for bathing.</p> <p>During an interview on 12/15/2015 at 7:36 A.M. administrative nurse F said resident bathing preferences were assessed on admission and quarterly with care planning. He/she said the most recent care plan summary/assessment dated 12/3/2015 did not address bathing preference.</p> <p>During an interview on 12/15/2015 at 11:06 A.M. administrative nursing staff D said he/she expected staff to assess personal preferences quarterly prior to the care plan assessment and document the preference in the clinical record and care plan.</p> <p>The facility failed to provide a requested policy on resident choices.</p> <p>The facility failed to provide bathing preference.</p>	F 242		
F 250	483.15(g)(1) PROVISION OF MEDICALLY	F 250		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 SS=F	Continued From page 42 RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility reported a census of 80 residents. There were 18 residents in the sample. Based on observation, interview, and record review the facility failed to implement facility developed social service interventions for 10 sampled residents and 1 unsampled resident who had verbal and physical resident to resident altercations. (#6, #11, #25, #29, #30, #35, #73, #75, #77, #84, and 1 unsampled resident) Findings included: - Review of resident #77's signed physician order sheet dated 11/4/2015 documented the following diagnoses: bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods) and depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness). Review of the annual MDS (Minimum Data Set) dated 3/19/2015 documented a BIMS (Brief Interview for Mental Status) score of 15, which indicated intact cognition. The resident had no hallucinations (seeing and/or hearing things, which were not real) or delusions (an untrue persistent belief), displayed no physical or verbal aggression towards others, and did not reject cares.	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 43</p> <p>Review of the quarterly MDS dated 9/10/2015 documented a BIMS score of 15, which indicated intact cognition. The resident had no hallucinations or delusions, displayed no physical aggression, had 1 to 3 days of verbal aggression directed towards others, and did not reject cares.</p> <p>Review of the Mood CAA (Care Area Assessment) dated 3/20/2015 documented the resident took medication to treat bipolar disorder and depression. Staff observed the resident have occasional anger outbursts and a quick temper, which were redirected with calm counsel and privacy.</p> <p>Review of the care plan dated 9/11/2015 documented the resident had no plans to discharge. The care plan was revised on 10/18/2015 and documented the resident took psychotropic medications to control his/her mood related to bipolar disorder and depression. The care plan directed staff to monitor and document behaviors of irritability, such as refusing cares, isolation, and agitation.</p> <p>Review of an incident investigation documented on 10/18/2015 at 5:00 P.M. the resident and resident #30 was in the dining room and argued over seating. The resident hit resident #30 in his/her face twice, which caused swelling to his/her right eye. The facility reported corrective actions taken by the facility included; immediate separation and assessment, police notified, increased visual monitoring when in the same areas of the building and signs/symptoms of anxiety and aggression were present, the resident was taken to the hospital for a medication review and psychiatric evaluation, physician notified of incident, social worker met with the residents and discussed dining room choices, and dining room</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 44</p> <p>rules and etiquette were discussed in the October Resident Council Meeting.</p> <p>Review of social service notes dated 10/18/2015 through 10/19/2015 lacked documentation of social service meeting with the resident to discuss dining room choices.</p> <p>Review of October 2015 resident council minutes lacked discussion of dining room rules and etiquette.</p> <p>Review of the residents clinical record documented the facility gave the resident a 30 day notice to discharge on 11/11/2015 and the resident discharged on 12/3/2015.</p> <p>Review of the clinical record dated 10/18/2015 through 12/13/2015 lacked information regarding the visit to the hospital for a medication review and psychiatric evaluation.</p> <p>Review of hospital records faxed to the facility on 12/14/2015 documented the resident was evaluated by the psychiatric nurse practitioner and the resident reported he/she hit a resident with his/her fist twice in the eye. The hospital recommended the resident return to the clinic for an appointment in December or sooner if agitation, anger, or other symptoms occurred.</p> <p>During an interview on 12/14/2015 at 12:06 P.M. direct care staff S he/she knew the resident gave resident #30 a black eye during a physical altercation.</p> <p>During an interview on 12/14/2015 at 2:00 P.M. direct care staff R said he/she was not aware of any altercations between the resident and resident #30 and the resident was not violent.</p>	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 45 During an interview on 12/14/2015 at 1:46 P.M. licensed nursing staff L said he/she recalled the resident hit resident #30 in the face with his/her fist twice and resident #30 got a black eye. Staff L said the resident was not normally violent towards others. During an interview on 12/15/2015 at 8:02 A.M. social service staff JJ said he/she was not aware of the results of the resident's visit to the hospital for a medication review and psychiatric evaluation and if known he/she would ensure the resident follow up with the hospital as recommended following the physical altercation between him/her and resident #30. Staff JJ said he/she did not document follow up on the verbal and physical altercations between the resident and resident #30 because resident #77 bullied others, the facility had difficult times with him/her, and the facility had already intervened. Staff JJ said he/she did not complete the corrective action interventions and was not always made aware of the facility developed corrective plan interventions. During an interview on 12/15/2015 at 10:38 A.M. administrative nursing staff D said he/she expected staff to follow the corrective action plan developed following an altercation between residents and for staff to document the intervention and resident responses in the medical record. Staff D said he/she expected the charge nurse to obtain visit notes from the hospital following the visit and confirmed the facility obtained the correspondence from the hospital visit of 10/19/2015 on 12/14/2015. He/she said the facility staff should follow the hospital recommendation to manage his/her behaviors.	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 46</p> <p>The facility failed to provide a social service policy as requested. The facility provided a social service director job description dated 12/20/1999, which documented the social worker was required to document per regulations and served as resident advocate when necessary.</p> <p>The facility failed to provide sufficient social services to ensure this resident received the care and services needed to manage his/her behaviors.</p> <p>- Review of resident #30's signed physician order sheet dated 12/4/2015 documented the following diagnoses: bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships), depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and mild intellectual disorders (a learning disability).</p> <p>Review of the annual MDS (Minimum Data Set) dated 6/18/2015 documented a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderate cognitive impairment. The resident had delusions, verbal aggression directed towards others, and did not reject cares. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the quarterly MDS dated 9/17/2015 documented a BIMS score of 12, which indicated moderate cognitive impairment. The resident had delusions, verbal aggression and other behaviors directed towards others, and he/she rejected cares for 1-3 of 7 days. The resident received 7</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 47</p> <p>days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the Cognitive CAA (Care Area Assessment) dated 6/19/2015 documented the resident had inattentiveness, disorganized thinking, and delusions.</p> <p>Review of the Mood and Behavior CAA dated 6/19/2015 documented the resident had bipolar disorder, borderline personality disorder, mild intellectual disability, and depression and took medications to treat the disorders.</p> <p>Review of the care plan dated 11/7/2015 documented the resident sought staff attention and reassurance and had difficulty managing his/her frustration. The resident paced and had inappropriate responses to verbal communication, displayed violent/aggressive behavior towards staff and other residents, and was aggressive at times when he/she had increased anxiety. The care plan directed staff to be patient and calm in response to anger and frustration and assist the resident with coping strategies to include; talking, breathing exercises, walking, an remind the resident of appropriate ways to handle his/her anger.</p> <p>Review of an incident investigation documented on 7/18/2015 at 5:12 P.M. the resident became agitated and began yelling in the dining room, which caused resident #84 to yell back. The resident hit resident #84 on the head and resident #84 kicked the resident on his/her arm and leg. The facility reported corrective action taken included; immediate separation and assessment, police notified, increased visual monitoring and staff presence while signs and symptoms of</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 48</p> <p>anxiety and aggression were present, staff administered an as needed medication for anxiety and aggression, and the social worker spoke with the resident to ensure physical and emotional well being and discussed non-violent ways to handle stressful situations.</p> <p>Review of nursing progress notes dated 7/18/2015 lacked documentation of the altercation that occurred on 7/18/2015.</p> <p>Review of the MAR (Medication Administration Record) dated 7/18/2015 lacked documentation of administration of an as needed medication for anxiety and aggression.</p> <p>Review of social service notes dated 7/18/2015 through 7/20/2015 lacked documentation of the altercations which occurred on 7/18/2015 and lacked discussion between social services and the resident regarding physical and emotional well-being and ways to handle stressful situations.</p> <p>Review of an incident investigation documented on 10/18/2015 at 5:00 P.M. the resident and resident #77 was in the dining room and argued over seating. Resident #77 hit the resident in his/her face twice, which caused swelling to his/her right eye. The facility reported corrective actions taken by the facility included; immediate separation and assessment, police notified, increased visual monitoring when in the same areas of the building and signs/symptoms of anxiety and aggression were present, staff administered an as needed medication for pain, physician notified of incident, social worker met with the residents and discussed dining room choices, and dining room rules and etiquette were discussed in the October Resident Council Meeting.</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 49</p> <p>Review of social service notes dated 10/18/2015 through 10/19/2015 lacked documentation of social service meeting with the resident to discuss dining room choices.</p> <p>Review of October 2015 resident council minutes lacked discussion of dining room rules and etiquette.</p> <p>During an observation on 12/09/2015 at 12:12 P.M. the resident sat at the dining room table and interacted appropriately with tablemate's and staff.</p> <p>During an observation on 12/09/2015 at 2:58 P.M. the resident sat at the dining room table alone. He/she was alert, smiled, and interacted with staff and resident as they passed his/her table.</p> <p>During an interview on 12/09/2015 at 2:54 P.M. the resident said there were always fights going on in the dining room. He/she said residents did not like him/her and he/she did not know why. The resident said he/she tells staff when resident #84 threatens him/her and staff does not care.</p> <p>During an interview on 12/09/2015 at 3:38 P.M. direct care staff Q said the resident and resident #84 did not get along and were verbally and physically abusive towards each other. Staff Q said verbal and physical altercations happen often in the dining room and he/she did not report unless actual physical harm occurred.</p> <p>During an interview on 12/10/2015 at 10:02 A.M. direct care staff R said he/she witnessed resident #84 reach out to strike other resident, but did not report to his/her charge nurse or administration because he/she did not actual hit another resident.</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 50 During an interview on 12/14/2015 at 8:22 A.M. direct care staff S said the resident and resident #84 had numerous verbal and physical altercations in the past and he/she witnessed resident #84 hit the resident many times. Staff S said he/she heard of an incident when resident #77 hit the resident and the resident got a black eye. Staff S he/she let the nurse know of altercations if a resident got hit or hurt. During an interview on 12/14/2015 at 10:41 A.M. licensed nursing staff I said he/she was not aware of any physical altercations between the resident and other residents. Staff I said he/she was told of incidents usually through hearsay and sometimes in report, "but not always". Staff I said he/she believed altercations between resident were not communicated appropriately and he/she often heard of resident altercations weeks after altercations occurred. During an interview on 12/15/2015 at 10:19 A.M. licensed nursing staff K said if a resident altercation occurred which had the potential for harm or caused harm he/she notified the nursing administrator either by phone call or an email and only documented resident to resident altercations in the clinical record if administration told him/her to document. During an interview on 12/14/2015 at 11:41 A.M. social service staff JJ said he/she did not document follow up on the verbal and physical altercation that occurred between the resident and resident #84 according to the facility developed corrective action plan because the altercation was verbal and no one was hurt. Staff JJ said he/she did not document follow up on the verbal and physical altercations between the	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 51</p> <p>resident and resident #77 because resident #77 bullied others, the facility had difficult times with him/her, and the facility had already intervened. Staff JJ said he/she did not complete the corrective action interventions and was not always made aware of the facility developed corrective plan interventions.</p> <p>During an interview on 12/15/2015 at 10:38 A.M. administrative nursing staff D said he/she expected staff to follow the corrective action plan developed following an altercation between residents and for staff to document the intervention and resident responses in the medical record. Staff D said he/she expected the charge nurse to obtain visit notes from the hospital following the visit and confirmed the facility obtained the correspondence from the hospital visit of 10/19/2015 on 12/14/2015. He/she said the facility staff should follow the hospital recommendation to manage his/her behaviors.</p> <p>The facility failed to provide a social service policy as requested. The facility provided a social service director job description dated 12/20/1999, which documented the social worker was required to document per regulations and served as resident advocate when necessary.</p> <p>The facility failed to provide sufficient social services to ensure this resident received the care and services needed to manage his/her behaviors.</p> <p>- Review of resident's #6's quarterly Minimum Data Set dated 11/5/15 included the resident scored 7 (severely impaired cognition) on the Brief Interview for Mental Status, had</p>	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 52</p> <p>hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), displayed verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others 4 to 6 days but less than daily during the 7 day assessment period and ambulated independently in the room/corridor.</p> <p>The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/31/14 included the resident had diagnoses of Schizoaffective Disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) which could affect his/her cognition.</p> <p>The resident's Activity of Daily Living CAA dated 12/31/14 included the resident ambulated independently.</p> <p>The resident's Behavioral Symptoms CAA dated 12/31/14 included the resident was physically agitated at times, paced and made physical gestures or was sexually inappropriate. The resident also exhibited verbal outbursts, such as yelling (either when really excited or upset), had rapid speech, or responded inappropriately to questions. The resident's behaviors was difficult to redirect at times and staff currently monitored the resident for physical agitation.</p> <p>Review of the resident's Level II PASAAR (Preadmission Screening and Resident Review) dated 6/17/1995 documented the following</p>	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 53</p> <p>recommendations: Community based mental health services to monitor mental health needs. Psychiatrist to monitor the mental health illness and psychiatric medications.</p> <p>Review of the resident's clinical record lacked evidence the resident received community based mental health services to monitor his/her mental health needs.</p> <p>A psychiatrist treatment note dated 11/5/15 documented the resident continued to have problems which was mostly violent behavior toward others and being disruptive.</p> <p>A physician progress note dated 11/30/15 documented the resident was chronically ill with agitated demeanor. The resident did not appear stable from mental standpoint, and the resident apparently had outbursts again which were a problem.</p> <p>Review of a complaint investigation included that on 1/10/15 at approximately 4:30 P.M. resident #29 was in the dining room and spoke to unseen others. Resident #6 was near by and thought resident #29 was speaking to him/her and got agitated and began arguing with the resident. Staff heard the arguing and rushed to the location but before they were able to intervene resident #6 reached out and hit resident #29 in his/her back.</p> <p>The investigation included the facility implemented the following corrective actions: staff separated the residents and initiated assessments, notified local law enforcement and neither resident filed charges. Staff increased visual monitoring for both residents when the residents exhibited signs/symptoms of anxiety</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 54</p> <p>and aggression. Both residents were offered and administered as needed medications for agitation/anxiety. The social worker met with both residents and discussed non-violent ways to handle stressful situations which could result in acts of aggression.</p> <p>The investigation summary included staff regularly monitored the interventions and adjusted them as needed to minimize the chance of a situation like this happening in the future.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed with the residents non-violent ways to handle stressful situations which could result in acts of aggression.</p> <p>Resident's #75 clinical record identified the resident was deaf (unable to hear) and had mild intellectual difficulties.</p> <p>The resident's (resident #75) annual Minimum Data Set (MDS) identified the resident had moderately impaired cognition.</p> <p>Review of a complaint investigation documented on 9/8/15 at approximately 11:45 A.M. the resident became agitated and believed that his/her roommate, resident #75 was talking about him/her. The resident hit resident #75 on the side of his/her head. Staff was near by and immediately intervened by separating the residents and redirected resident #75 away from the area. Resident #6 remained in his/her room and swore and acted aggressive toward staff at which time staff offered and administered the resident an as needed medication for for</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 55 agitation/anxiety.</p> <p>The investigation included the facility implemented the following interventions. Staff separated the residents and assessments revealed neither of the residents were injured. Staff notified local law enforcement of the incident and no report was filled. Staff increased visual monitoring and staff presence for resident #6 when he/she exhibited signs/symptoms of anxiety and aggression. The social worker met with resident #6 and discussed the situation and appropriate ways to handle himself/herself if he/she felt anxious or upset. A room change was arranged and agreed upon by both individuals. Resident #6's medications were evaluated with changes made as physician ordered.</p> <p>Review of the residents' clinical records lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed with resident #6 appropriate ways to handle himself/herself when he/she felt anxious or upset.</p> <p>Review of a complaint investigation documented on 12/3/15 at approximately 3:30 A.M. resident #6 and resident #73 got into an argument near the nurses station. The charge nurse attempted to separate the residents but resident #6 hit the charge nurse on the side of his/her face and pushed resident #73 which caused the resident #73 to fall to the ground. Resident #73 got himself/herself off of the floor and hollered at resident #6 and staff redirected resident #73 to a chair and redirected resident #6 to his/her room. Resident #6 told staff resident #73 was talking about him/her which caused him/her to become irritated.</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 56</p> <p>The investigation included the facility implemented the following corrective actions: staff immediately intervened and separated the residents. Assessments were initiated and no injuries were observed. Staff notified local law enforcement of the incident and no charges were filed.</p> <p>Staff offered and administered resident #6 an as needed medication. Staff increased visual monitoring for both residents when the residents exhibited signs/symptoms of agitation.</p> <p>The investigation summary included staff regularly monitored the interventions and adjusted them as needed to minimize the chance of a situation like this form occurring again.</p> <p>On 12/8/15 at approximately 10:05 A.M. a surveyor received permission from the resident to enter his/her room for a resident interview. Observation revealed resident #6 and resident #75 were roommates. During the interview the resident demanded the surveyor look at a photo album and the surveyor explained to the resident he/she would after the interview. The resident became upset, yelled at the surveyor and attempted to hit the surveyor in the head with the album. Staff immediately came to the resident's room and redirected the resident.</p> <p>On 12/9/15 at 8:05 A.M. the resident was in the dining room yelling and nursing administrative staff D stated the resident hit him/her. Staff redirected the resident and the resident yelled at staff to get his/her hands off of him/her.</p> <p>On 12/14/15 at approximately 7:10 A.M. the resident exited his/her room, spoke to the surveyors and ambulated independently to the</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 57</p> <p>dining room. As the resident reached the entrance to the dining room the resident yelled an expletive. Staff escorted the resident to his/her room and the resident yelled get your hands off of him/her.</p> <p>On 12/9/15 at approximately 5:15 P.M. administrative nursing staff D stated the resident did not receive outside mental health services because the agencies that offered the service was not able to bill for mental health services when residents resided in a nursing facility.</p> <p>On 12/9/15 at 3:00 P.M. staff KK confirmed resident #6 and resident #75 were roommates. He/she stated both residents became upset when staff attempted the room change so staff allowed the residents to remain in the same room.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. Staff JJ stated he/she would not have documented anything regarding this incident because neither resident sustained injuries and staff immediately intervened.</p> <p>The residents clinical record lacked evidence the facility identified the medically-related social service needs of the resident(s) and assured that</p>	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 58</p> <p>the residents needs were met by the appropriate disciplines. The residents clinically record also lacked evidence the facility provided medically related social services to assist the residents in maintaining or improving their ability to manage his/her mental, and psychosocial needs.</p> <p>The facility provided the following regarding the facility's Social Service Policy and Procedure revised on 12/20/99. The Social Service Director was required to direct the development and implementation of programs and interventions to perform duties that enhanced the psychosocial, mental and emotional well being of residents.</p> <p>The facility failed to have systems in place to ensure residents received medically related social service to meet the residents mental and psychosocial needs.</p> <p>- Resident #35's electronic medical record included the resident had diagnoses that included Bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods), Cerebral Palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), Depressive Disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and a history of falls.</p> <p>The resident's annual Minimum Data Set dated 10/29/15 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had hallucinations, delusions, displayed verbal behavioral symptoms toward others, and other behavioral symptoms not directed toward others 4 to 6 days, but less than daily during the 7 day assessment period. The resident required</p>	F 250		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 59</p> <p>extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, dressing, toilet use, and personal hygiene and the activity of walking in the room/corridor did not occur. The resident received an antipsychotic and an antidepressant medication 7 of the 7 days during the assessment period.</p> <p>The resident's care plan dated 11/5/15 included staff monitored the resident's behavior for restlessness, hallucinations, yelling and delusions.</p> <p>Review of a complaint investigation with an incident date of 11/19/15 documented that at approximately 1:30 A.M. this resident (#35) and an unsampled residential health care resident (RHC) got into an argument in the dining room because the RHC resident thought resident #35 called him/her names. The RHC resident pushed resident #35's head and kicked his/her chair. Staff was near by and separated the residents.</p> <p>The investigation included the facility implemented the following corrective actions: Staff immediately separated the residents and assessments revealed both resident were free from injury. The facility increased staff presence while the residents were in the same areas of the building and exhibited signs/symptoms of anxiety and aggression. The social worker discussed with both residents non-violent ways to handle stressful situations which could result in acts of aggression/violence. Staff was counseled on proper ways to communicate with resident #35 when he/she experienced delusions. The RHC resident was taken to a local hospital for a psychiatric evaluation and he/she later returned to the facility per his/her request.</p>	F 250		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 60</p> <p>The resident's clinical record did not have an reference to the incident.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed with the residents non-violent ways to handle stressful situations. There was also no evidence to support the social worker counseled staff on proper way to communicate with resident #35 when he/she experienced delusion. There was also no evidence to support the RHC resident had a psychiatric evaluation.</p> <p>The residents clinical record lacked evidence the facility identified the medically-related social service needs of the resident(s) and assured that the residents needs were met by the appropriate disciplines. The residents clinically record also lacked evidence the facility provided medically related social services to assist the residents in maintaining or improving their ability to manage his/her mental, and psychosocial needs.</p> <p>On 12/10/15 at 8:15 A.M. the RHC resident ambulated independently in the facility.</p> <p>On 12/10/15 at 2:30 P.M. resident #35 self propelled his/her wheelchair in the hallways.</p> <p>On 12/10/15 at 1:30 P.M. resident #35 propelled his/her wheelchair down the RHC hall.</p> <p>During Stage 1 of the survey resident #35 reported to a surveyor that approximately a month ago a resident hit him/her and staff was aware of the incident. Resident #35 provided the name of the resident to the surveyor.</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 61</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she was aware of the incident. Staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. Staff JJ stated he/she could not recall the incident and after reviewing the investigation, he/she stated since the RHC resident received outside interventions, nursing staff would have documented on the corrective actions.</p> <p>On 12/15/15 at approximately 3:30 P.M. administrative nursing staff D stated the RHC resident did not receive the psychiatric evaluation as planned.</p> <p>The resident's clinical record lacked evidence the facility identified the medically-related social service needs of the resident(s) and assured that the residents needs were met by the appropriate disciplines. The residents clinically record also lacked evidence the facility provided medically related social services to assist the residents in maintaining or improving their ability to manage his/her mental, and psychosocial needs.</p> <p>The facility provided the following regarding the facility's Social Service Policy and Procedure revised on 12/20/99. The Social Service Director was required to direct the development and</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 62</p> <p>implementation of programs and interventions to perform duties that enhanced the psychosocial, mental and emotional well being of residents.</p> <p>The facility failed to have systems in place to ensure residents received medically related social service to meet the residents mental and psychosocial needs.</p> <p>- Review of a complaint investigation with an incident date of 9/6/15 included on 9/6/15 at approximately 4:30 P.M. resident #25 was in the dining room and became agitated. An unsampled Resident Health Care Facility Resident (RHC) told resident #25 to be quiet which started an argument between the 2. The RHC resident walked over to where resident #25 sat and pushed the resident in the head. Staff was near by and immediately intervened and separated the residents.</p> <p>The investigation included the facility implemented the following corrective actions: Staff immediately intervened and separated the residents. Assessments were initiated and no injuries were noted. The facility notified local law enforcement and neither residents wanted to file charges. Staff increased visual monitoring and staff presence when the residents were in the same area of the building and when showing signs/symptoms of agitation and anxiety. Staff offered and administered resident #25 and as needed medication for agitation/anxiety and the facility requested a medication evaluation for both residents. The social worker followed up with both residents to regarding his/her emotional well-being and educated the residents on ways to handle himself/herself in times of increased stress.</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 63</p> <p>The resident's clinical record did not have an reference to the incident.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker educated the residents on ways to handle himself/herself in times of increased stress. There was also no evidence to support the facility requested medication evaluations for the residents as planned.</p> <p>On 12/10/15 at 8:15 A.M. the RHC resident ambulated independently in the facility.</p> <p>On 12/10/15 at 12:30 resident #25 sat at a dining room table.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. Staff JJ stated he/she would not have documented anything regarding this incident because neither resident sustained injuries and staff immediately intervened.</p> <p>The residents clinical record lacked evidence the facility identified the medically-related social service needs of the resident(s) and assured that</p>	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 64</p> <p>the residents needs were met by the appropriate disciplines. The residents clinically record also lacked evidence the facility provided medically related social services to assist the residents in maintaining or improving their ability to manage his/her mental, and psychosocial needs.</p> <p>The facility provided the following regarding the facility's Social Service Policy and Procedure revised on 12/20/99. The Social Service Director was required to direct the development and implementation of programs and interventions to perform duties that enhanced the psychosocial, mental and emotional well being of residents.</p> <p>The facility failed to have systems in place to ensure residents received medically related social service to meet the residents mental and psychosocial needs.</p> <p>- Review of a complaint investigation revealed that on 6/5/15 at approximately 10:20 A.M. resident #25 and resident #84 got into altercation on the back patio of facility. Resident #25 spoke with a staff regarding he/she was not going to take his/her medications until after he/she smoked. Resident #84 told resident #25 to shut up, resident #25 responded by yelling at resident #84 and told him/her to mind his/her own business. Resident #84 then walked over and threw his/her soda on resident #25. As retaliation resident #25 threw his/her cup of water on resident #84 and the residents grabbed at other's clothes and hair. Resident #25 pulled resident's #84's hair and resident #84 hit resident #25 in the groin and the staff intervned and stopped the altercation.</p> <p>The investigation included the facility implemented the following corrective actions.</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 65</p> <p>Staff immediately separated the residents and staff initiated assessments. Staff increased visual monitoring when the resident exhibited signs/symptoms of anxiety and aggression and increased staff presence when the residents were in the same area of the building and exhibited signs/symptoms of anxiety and aggression. Staff contacted local law enforcement and no charges were pressed by either party. Both resident were offered as needed medications for pain and anxiety. The social worker would discuss non-violent ways to handle stressful situations which could result in acts of aggression. The social worker followed up with the residents to ensure his/her physical and emotional well-being. Resident #84 was counseled on appropriate ways to address his/her peers that would not lead to an altercation.</p> <p>The resident's clinical record did not have an reference to the incident.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker educated the residents on non-violent ways to handle himself/herself in stressful situations and/or followed up with the residents as planned.</p> <p>Review of a complaint investigation revealed on 8/24/15 at approximately 1:15 A.M. resident #25 and resident #77 got into a verbal altercation in the dining room. Staff intervened and redirected resident #77 away from the area at which point resident #84 hollered at resident #25 and stated he/she was going to beat him/her. Resident #84 walked over to resident #25 and hit him/her on the side of his/her head. Staff immediately</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 66</p> <p>separated the residents and and notified the charge nurse.</p> <p>The investigation included the facility took the following corrective actions: Staff immediately intervened and separated the residents. Staff initiated assessments and no injuries were noted. Staff notified local law enforcement of the incident and no charges were filed. Staff increased visual monitoring and staff presence when the residents exhibited signs/symptoms of anxiety and aggression. Both residents were offered and administered as needed medications for agitation/anxiety. The social worker met with the resident to ensure the residents physical and emotional well-being and to discuss non-violent ways to handle stressful situations.</p> <p>The resident's clinical record did not have an reference to the incident.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker educated the residents on non-violent ways to handle himself/herself in stressful situations and/or followed up with the residents as planned.</p> <p>Review of a complaint investigation documented on 10/14/15 at approximately 4:10 P.M. resident #84 walked to the dining room and demanded that resident #11 move out of the chair where he/she sat so he/she could have it, resident #11 responded "no" and told resident #84 that he/she would need to find somewhere else to sit. The residents argued and before staff could intervene resident #84 kicked at resident while he/she was sitting down, in return resident #11 kicked</p>	F 250			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 67</p> <p>resident #84 which caused him/her to fall back on the ground. Resident #84 got himself/herself up off of the floor, hollered at resident #11 and called the resident names.</p> <p>The investigation included the facility implemented the following corrective actions: staff immediately separated the residents and initiated assessments and no injuries were observed. Staff notified local law enforcement, law enforcement spoke with the residents and no report was filed. Staff increased visual monitoring for both residents when the residents exhibited signs/symptoms of anxiety and aggression. Both residents were offered as needed medications for agitation/anxiety which they refused. The social worker met with both residents and discussed socially appropriate behaviors and how to handle himself/herself in stressful situations.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas and also lacked evidence to support the social worker discussed socially appropriate behaviors and how to handle himself/herself in stressful situations.</p> <p>On 12/10/15 at 12:30 resident #84 sat at a dining room table.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p>	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 68 On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. Staff JJ stated he/she would not have documented anything regarding this incident because neither resident sustained injuries and staff immediately intervened. The residents clinical record lacked evidence the facility identified the medically-related social service needs of the resident(s) and assured that the residents needs were met by the appropriate disciplines. The residents clinically record also lacked evidence the facility provided medically related social services to assist the residents in maintaining or improving their ability to manage his/her mental, and psychosocial needs. The facility provided the following regarding the facility's Social Service Policy and Procedure revised on 12/20/99. The Social Service Director was required to direct the development and implementation of programs and interventions to perform duties that enhanced the psychosocial, mental and emotional well being of residents. The facility failed to have systems in place to ensure residents received medically related social service to meet the residents mental and psychosocial needs.	F 250			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change	F 274			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 274	<p>Continued From page 69</p> <p>means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 80 residents of which 18 residents were included in the sample. Based on observation interview and record review the facility failed to conduct a timely comprehensive assessment for resident #22 who had significant weight loss and increased depression (an abnormal state characterized by exaggerated feelings of sadness, worthlessness, and emptiness).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #22's signed physician order sheet dated 12/4/2015 documented the following diagnoses: paranoid schizophrenia (a psychotic disorder characterized by gross distortion of reality), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression, and insomnia (an inability to sleep). <p>Review of the admission MDS (Minimum Data Set) dated 6/26/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident had hallucinations (seeing and/or hearing things, which were not real), delusions (an untrue persistent belief), and mild depression. The resident was independent with eating, weighed</p>	F 274			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 274	<p>Continued From page 70</p> <p>184 pounds, was 75 inches tall, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period.</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 9/24/2015 documented a BIMS score of 15, which indicated intact cognition. The resident had hallucinations, delusions, and moderate depression. The resident was independent with eating with set up assistance from staff, weighed 170 pounds, was 75 inches tall, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 7/1/2015 documented the resident had delusions and hallucinations, paced the halls, and talked to unseen persons on invisible phones.</p> <p>The Nutritional CAA did not trigger for review.</p> <p>Review of the care plan dated 9/24/2015 documented the resident was happy with his/her current weight, wanted to maintain his/her weight, and notified staff if he/she changed his/her mind. The care plan directed staff to provide a double meat sandwich if requested, offer a room tray if he/she did not want to eat in the dining room, provide a regular diet, and assess his/her nutritional status once a year or if his/her condition changed, weight monthly and as needed, provide a snack every night before bed, and review nutrition quarterly. The care plan documented the resident slept much of the day,</p>	F 274			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 274	<p>Continued From page 71</p> <p>stayed up at night, and missed meals. He/she did not want staff to disturb him/her to ask about meals and would let staff know when he/she wanted to eat.</p> <p>The resident weighed 185 lbs (pounds) on 6/18/2015 and 170 lbs on 9/18/2015, which indicated a weight loss of 8.10% (percent) over 90 days. The resident weighed 166 lbs on 12/4/2015, which indicated a weight loss of 10.2% in less than 180 days.</p> <p>Review of laboratory results dated 7/2/2015 recorded an albumin (protein in the blood) level of 4.0, which was within normal limits.</p> <p>Review of a dietitian nutritional assessment dated 7/22/2015 documented the resident had a regular diet, fed himself/herself, and weighed 176.7 lbs. The resident lost 8.3 pounds since admission (4.5%) and chose not eat some meals. The resident's weight was appropriate, labs reflected adequate nutrition, and weight gain was not necessary. Recommendation was to continue to monitor for further weight loss and encourage sandwiches/foods during the day.</p> <p>Review of meal intake records dated November and December 2015 lacked documentation of meal consumption for this resident.</p> <p>Review of a physician order sheet dated 12/4/2015 included the following: Weigh monthly Regular Diet Fluoxetine (a medication used to treat depression, which may decrease appetite) 10 mg (milligrams) by mouth daily for depression</p> <p>During an observation on 12/09/2015 at 12:07 P.M. the resident sat at the dining room table and</p>	F 274			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 274	<p>Continued From page 72</p> <p>staff served him/her barbeque meatballs, green beans, cake, and juice. The resident ate 100% of meal independently and drank 75% of juice.</p> <p>During an observation on 12/10/2015 at 7:11 A.M. the resident sat at the dining room table and was served scrambled eggs, French toast sticks with syrup, 2 bowls of cereal with 2 cartons of milk, and sausage links. The resident ate 90% of French toast, 100% of eggs and drank both cartons of meal independently. The resident emptied the 2 bowls of cereal in the trash and left the dining room.</p> <p>During an interview on 12/09/2015 at 3:06 P.M. the resident said he/she lost 12 pounds in the past 2 months and he/she tried to eat more food. The resident said he/she had no appetite and did not try to lose weight.</p> <p>During an interview on 12/09/2015 at 3:36 P.M. direct care staff Q said the resident stayed up late at night, slept a lot during the day, took staff multiple attempts to awaken for supper, and ate well when he/she came out for supper. Staff Q was not sure if the resident lost weight.</p> <p>During an interview on 12/10/2015 at 9:59 A.M. direct care staff R said the resident was independent with eating. He/she said the resident did not always come out of breakfast, but usually came to the dining room for lunch and usually ate 100%. Staff R said he/she was not sure if the resident lost weight.</p> <p>During an interview on 12/14/2015 at 10:20 A.M. licensed nursing staff I said the resident was on a regular diet and lost 19 pounds since he/she admitted on June 18, 2015. Staff I said MDS Coordinators tracked weight loss and usually put residents on weekly weights and supplements.</p>	F 274			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 274	<p>Continued From page 73</p> <p>Staff I confirmed the resident was not weighed weekly, did not receive a nutritional supplement, and staff did not document meal intake. During an interview on 12/14/2015 at 2:24 P.M. administrative nursing staff E stated he/she was made aware the resident lost weight on 12/13/2015 by dietary staff. He/she confirmed the resident lost a significant amount of weight his/her first 90 days of admission and continued to lose a significant amount of weight and had increased depression. Staff E said he/she was not sure if a significant change in status assessment was required.</p> <p>During an interview on 12/14/2015 at 9:30 A.M. dietary staff FF said he/she was not aware the resident lost a significant amount of weight and he/she was responsible for notifying the dietitian of weight loss.</p> <p>During an interview on 12/15/2015 at 10:55 A.M. administrative nursing staff D said he/she was not aware the resident lost a significant amount of weight, the facility overlooked the resident's weight loss, and staff made him/her aware of the weight loss of 12/14/2015. Staff D said staff should have considered a significant change in status assessment in September.</p> <p>During an interview on 12/15/2015 at 12:21 P.M. dietary consultant GG said he/she was not aware the resident lost a significant amount of weight until he/she received a call yesterday from the facility. Staff GG said he/she expected to notify him/her of the continued weight loss and said he/she would have seen the resident in September if the facility informed him/her of the weight loss.</p> <p>During an interview on 12/15/2015 at 10:05 A.M. physician consultant LL said the facility did not</p>	F 274			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 274	Continued From page 74 inform him/her of any weight loss since the resident admitted in June of 2015. Staff LL said he/she expected the facility to inform him/her of significant weight loss and said the resident's antidepressant medication, Fluoxetine, was an appetite depressant and may be a contributing factor to the resident's weight loss. Review of the RAI (Resident Assessment Instrument) dated 10/2013 documented a significant change in status assessment should be completed 14 days after determination that a significant change in condition occurred. The facility failed to recognize and conduct a timely comprehensive significant change in status assessment for this resident who experienced a significant weight loss and increased depression.	F 274			
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.	F 280			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 75 This Requirement is not met as evidenced by: The facility reported a census of 80 residents of which 18 residents were included in the sample. Based on observation interview and record review the facility failed to review and revise resident #22's care plan when he/she had significant weight loss. Findings included: - Review of resident #22's signed physician order sheet dated 12/4/2015 documented the following diagnoses: paranoid schizophrenia (a psychotic disorder characterized by gross distortion of reality), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and insomnia (an inability to sleep). Review of the admission MDS (Minimum Data Set) dated 6/26/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident had hallucinations (seeing and/or hearing things, which were not real), delusions (an untrue persistent belief), and mild depression. The resident was independent with eating, weighed 184 pounds, was 75 inches tall, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period. Review of the quarterly MDS (Minimum Data Set)	F 280		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 76</p> <p>dated 9/24/2015 documented a BIMS score of 15, which indicated intact cognition. The resident had hallucinations, delusions, and moderate depression. The resident was independent with eating with set up assistance from staff, weighed 170 pounds, was 75 inches tall, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 7/1/2015 documented the resident had delusions and hallucinations, paced the halls, and talked to unseen persons on invisible phones.</p> <p>The Nutritional CAA did not trigger for review.</p> <p>Review of the care plan dated 9/24/2015 documented the resident was happy with his/her current weight, wanted to maintain his/her weight, and notified staff if he/she changed his/her mind. The care plan directed staff to provide a double meat sandwich if requested, offer a room tray if he/she did not want to eat in the dining room, provide a regular diet, and assess his/her nutritional status once a year or if his/her condition changed, weight monthly and as needed, provide a snack every night before bed, and review nutrition quarterly. The care plan documented the resident slept much of the day, stayed up at night, and missed meals. He/she did not want staff to disturb him/her to ask about meals and would let staff know when he/she wanted to eat.</p> <p>The resident weighed 185 lbs (pounds) on 6/18/2015 and 170 lbs on 9/18/2015, which</p>	F 280			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 77</p> <p>indicated a weight loss of 8.10% (percent) over 90 days. The resident weighed 166 lbs on 12/4/2015, which indicated a weight loss of 10.2% in less than 180 days.</p> <p>Review of a dietitian nutritional assessment dated 7/22/2015 documented the resident had a regular diet, fed himself/herself, and weighed 176.7 lbs. The resident lost 8.3 pounds since admission (4.5%) and chose not eat some meals. The resident's weight was appropriate, labs reflected adequate nutrition, and weight gain was not necessary. Recommendation was to continue to monitor for further weight loss and encourage sandwiches/foods during the day.</p> <p>During an observation on 12/09/2015 at 12:07 P.M. the resident sat at the dining room table and staff served him/her barbeque meatballs, green beans, cake, and juice. The resident ate 100% of meal independently and drank 75% of juice.</p> <p>During an observation on 12/10/2015 at 7:11 A.M. the resident sat at the dining room table and was served scrambled eggs, French toast sticks with syrup, 2 bowls of cereal with 2 cartons of milk, and sausage links. The resident ate 90% of French toast, 100% of eggs and drank both cartons of meal independently. The resident emptied the 2 bowls of cereal in the trash and left the dining room.</p> <p>During an interview on 12/09/2015 at 3:06 P.M. the resident said he/she lost 12 pounds in the past 2 months and he/she tried to eat more food. The resident said he/she had no appetite and did not try to lose weight.</p> <p>During an interview on 12/09/2015 at 3:36 P.M. direct care staff Q said the resident stayed up late</p>	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 78</p> <p>at night, slept a lot during the day, took staff multiple attempts to awaken for supper, and ate well when he/she came out for supper. Staff Q was not sure if the resident lost weight.</p> <p>During an interview on 12/10/2015 at 9 :59 A.M. direct care staff R said the resident was independent with eating. He/she said the resident did not always come out of breakfast, but usually came to the dining room for lunch and usually ate 100%. Staff R said he/she was not sure if the resident lost weight.</p> <p>During an interview on 12/14/2015 at 10:20 A.M. licensed nursing staff I said the resident was on a regular diet and lost 19 pounds since he/she admitted on June 18, 2015. Staff I said MDS Coordinators tracked weight loss and usually put residents on weekly weights and supplements. Staff I confirmed the resident was not weighed weekly, did not receive a nutritional supplement, and staff did not document meal intake.</p> <p>During an interview on 12/14/2015 at 2:24 P.M. administrative nursing staff E stated he/she was made aware the resident lost weight on 12/13/2015 by dietary staff. He/she confirmed the resident lost a significant amount of weight his/her first 90 days of admission and continued to lose a significant amount of weight. Staff E said he/she revised the resident's care plan on 9/8/2015 and directed staff to remind the resident he/she had sandwiches available upon request. Staff E said the care plan should reflect the resident's significant weight loss and confirmed the care plan was not revised.</p> <p>During an interview on 12/14/2015 at 9:30 A.M. dietary staff FF said he/she was not aware the resident lost a significant amount of weight and</p>	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 79 he/she was responsible for notifying the dietitian of weight loss. During an interview on 12/15/2015 at 10:55 A.M. administrative nursing staff D said he/she was not aware the resident lost a significant amount of weight, the facility overlooked the resident's weight loss, and staff made him/her aware of the weight loss of 12/14/2015. Staff D said he/she expected the care plan to reflect the resident's significant weight loss. The facility used the RAI (Resident Assessment Instrument) as guidelines to review and revise resident care plans. The RAI Manual dated 5/2013 documented the care plan reflected the resident's needs and must be reviewed and revised periodically. The facility failed to review and revise the care plan for this resident who had a significant weight loss.	F 280		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This Requirement is not met as evidenced by: The facility had a census of 80 residents. The sample included 18 residents. Based upon observation, record review and interview the facility failed to perform appropriate treatment and services to maintain grooming/personal hygiene for 2 (#66, #71) of 3 residents sampled for activity of daily living tasks.	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 311	<p>Continued From page 80</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #66's quarterly Minimum Data Set (MDS) dated 11/18/15 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, required set up help only for persona hygiene and required staff assistance in part of the bating activity. <p>The resident's Activity of Daily Living (ADL) Care Are Assessment (CAA) dated 4/9/15 documented the resident stated he/she required staff assistance with washing his/her hair only in the showers, and reported the resident required extensive assistance of 1 resident with completing showers.</p> <p>The resident's care plan effective 11/23/15 addressed the resident needed some set-up help at times with ADLs based on his/her level of pain.</p> <p>The resident's care plan did not include the resident had chin hairs and if the resident required staff assistance to remove the hairs .</p> <p>On 12/9/15 at 9:38 A.M. observation revealed the resident had several white chin hairs.</p> <p>On 12/10/15 at 12:40 P.M. observation revealed the resident had several long white strands of chin hairs.</p> <p>On 12/15/15 at 7:30 observation revealed the resident had several long white strands of chin hairs.</p> <p>On 12/15/15 at 8:12 A.M. direct care staff stated the resident was independent with</p>	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 311	<p>Continued From page 81</p> <p>showering/bathing and requested staff assistance if needed. He/she stated staff did not offer to assist the resident to remove the chin hairs on a routine basis.</p> <p>On 12/15/15 at 9:10 A.M. staff stated the resident required staff assistance with showers/bathing and the resident had not asked him/her for assistance to remove the chin hairs. He/she stated some residents preferred not to have the chin hairs removed and he/she did not know the resident's preference regarding his/her chin hairs.</p> <p>On 12/15/15 at approximately 2:30 administrative nursing staff D stated the resident's preference regarding the chin hairs should be addressed in the resident's care plan. He/she stated staff assisted residents with shaving on showers/bath days and as requested.</p> <p>The resident's Preference Form dated 4/1/15 did not address the resident's chin hairs.</p> <p>The facility failed to determine the resident's preference regarding the resident's chin hairs. This practice placed this resident at risk for not being properly groomed.</p> <p>- Review of resident #71's signed physician order sheet dated 12/18/2015 documented the following diagnoses: paranoid schizophrenia (a psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmented thoughts).</p> <p>Review of the annual MDS (Minimum Data Set) dated 6/25/2015 documented a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderate cognitive impairment. The required supervision and set up assistance with</p>	F 311			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 311	<p>Continued From page 82</p> <p>personal hygiene tasks and did not refuse cares.</p> <p>Review of the quarterly MDS dated 9/24/2015 documented a BIMS score of 14, which indicated intact cognition. The resident required supervision and set up assistance with personal hygiene and did not refuse cares.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 7/1/2015 documented the resident had inattentiveness, disorganized thinking, was alert and oriented and had delusional(untrue and persistent beliefs) and hallucinations (seeing and/or hearing things that were not real).</p> <p>Review of the ADL (activities of daily living) CAA dated 7/1/2015 documented the resident required supervision and cueing with ADL because he/she was easily distracted and off track.</p> <p>Review of the care plan dated 9/25/2015 documented the resident's face got easily irritated, chose to shave every 2-4 days, and in colder weather he/she sometimes grew a beard, and let the staff know when he/she did not want to shave.</p> <p>During an observation on 12/8/2015 at 10:26 AM the resident had facial hair/beard growth and his/her hair was uncombed.</p> <p>During an observation on 12/09/2015 at 12:37 P.M. the resident sat at the dining room table eating. The resident had beard growth and combed hair.</p> <p>During an observation on 12/09/2015 at 2:58 P.M. the resident sat in the dining room doing a group activity. The resident had beard growth and</p>	F 311			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 311	<p>Continued From page 83 combed hair.</p> <p>During an interview on 12/09/2015 at 12:45 P.M. the resident said he/she preferred to shave every shower, had a shower this morning and staff did not have time to assist him/her with shaving.</p> <p>During an interview on 12/09/2015 at 3:27 P.M. direct care staff Q said the resident was independent with ADL and the resident could shave him/herself. Staff Q said he/she was not sure what type of shaving equipment the resident had available and staff were directed to supervise all residents with shaving for safety. stand at side and watch him/her shave.</p> <p>During an interview on 12/10/2015 at 9:51 A.M. direct care staff R said the resident needed set up for showers and shaving, staff were suppose to watch all residents shave, and the resident probably shaved on his/her own.</p> <p>During an interview on 12/10/2015 at 10:45 A.M. direct care staff S said he/she usually helped the residents with bathing and after bathing the resident could go to the barber shop to shave with staff supervision. Staff S said the resident usually shaved every 2-3 days.</p> <p>During an interview on 12/14/2015 at 9:54 A.M. licensed nursing staff I said there was not always enough time for staff to supervise the resident with shaving per his/her preference.</p> <p>During an interview on 12/15/2015 at 11:06 A.M. administrative nursing staff D said he/she expected personal preferences to be assessed quarterly prior to the care plan assessment and staff meet the resident's shaving preference.</p>	F 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 311	Continued From page 84 The facility failed to provide a requested policy on personal preferences. The facility failed to provide ADL shaving assistance for this resident who required staff supervision with shaving.	F 311		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This Requirement is not met as evidenced by: The facility identified a census of 80 residents with 1 selected for the sample. Based on observation, record review, and interview, the facility failed to provide appropriate treatment for urinary incontinence for 1 (#3) resident. Findings included: - The December 2015 Physician's Order Sheet (POS) for resident #3 documented a diagnosis of arthropathy (a disease of the joint). The Quarterly Minimum Data Set (MDS) dated 10/2/15 noted staff reported short term and long term memory problems and moderately impaired decision making ability. It included documentation the resident required extensive assistance of two or more staff for transfers and toileting and was	F 315		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 315	<p>Continued From page 85</p> <p>frequently incontinent of urine (involuntary loss of urine).</p> <p>The Care Area Assessment (CAA) dated 7/8/15 for cognition noted the resident had a difficult time with staying on a topic. The CAA for urinary incontinence documented the resident was on a 2 hour toileting schedule. The CAA for Activities of Daily Living (ADLs) CAA noted the resident needed assistance with transfers and most of other ADLs.</p> <p>The care plan dated 7/23/15 noted the resident was on a check and change schedule every 2 hours.</p> <p>The urinary incontinence assessment dated 11/25/15 noted the resident was on a 2 hour check and change schedule, and he/she needed 2 staff assistance for all transfers.</p> <p>ADL records for September 2015, October 2015 and November 2015 noted the resident was usually incontinent of urine.</p> <p>The 3 day voiding (urinating) diary dated 11/22/15, 11/23/15 and 11/24/15 noted the resident voided every 2 to 3 hours and was incontinent of urine.</p> <p>Observation on 12/09/2015 at 12:00 P.M., 12:15 P.M., 12:30 P.M., 12:45 P.M., 1:00 P.M., and 1:15 P.M. the resident sat in a wheelchair.</p> <p>Observation on 12/09/2015 at 1:30 P.M. staff assisted the resident to transfer from the wheelchair to the bed. Observation of staff revealed they did not offer toileting to the resident.</p>	F 315			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 315	<p>Continued From page 86</p> <p>Observation on 12/09/15 at 1:45 P.M., 2:00 P.M., and 2:15 P.M. the resident laid in bed. The staff did not offer toileting to the resident from 12:00 P.M. through 2:17 P.M.</p> <p>Observation on 12/09/15 at 2:17 PM revealed the resident remained in his/her bed, and then staff was asked to check the resident's brief for incontinence. Further observation revealed the brief was wet.</p> <p>Interview on 12/09/15 at 2:20 P.M. direct care staff O stated he/she asked the resident every 2 hours if he/she needed to use the restroom.</p> <p>Interview on 12/14/15 4:28 P.M. direct care staff P stated he/she checked the resident every 1 to 2 hours and the resident required 2 staff assistance for toileting.</p> <p>Interview on 12/14/15 at 2:57 P.M. licensed nursing staff H stated the resident was incontinent and staff were to check him/her every 2 hours.</p> <p>Interview on 12/15/15 at 11:50 A.M. administrative nursing staff D expected nursing staff to follow the care plans and to toilet the resident every 2 hours.</p> <p>The facility did not provide a policy about incontinence.</p> <p>The facility failed to provide incontinence care to this cognitively impaired resident.</p>	F 315		
F 323 SS=F	<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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 87</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 80 residents. There were 18 residents in the sample. Based on observation, interview, and record review the facility failed to provide adequate staff supervision to prevent verbal and physical altercations for 10 sampled residents and 1 unsampled resident from verbal and physical abuse by failure to follow facility developed corrective actions when verbal and physical abuse occurred. (#6, #11, #25, #29, #30, #35, #73, #75, #77, #84, and 1 unsampled resident).</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #30's signed physician order sheet dated 12/4/2015 documented the following diagnoses: bipolar disorder (a major mental illness that caused people to have episodes of severe high and low moods), borderline personality disorder (a disorder characterized by disturbed and unstable interpersonal relationships), depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and mild intellectual disorders (a learning disability). <p>Review of the annual MDS (Minimum Data Set) dated 6/18/2015 documented a BIMS (Brief Interview for Mental Status) score of 12, which indicated moderate cognitive impairment. The resident had delusions, verbal aggression directed towards others, and did not reject cares.</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 88</p> <p>The resident received 7 days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the quarterly MDS dated 9/17/2015 documented a BIMS score of 12, which indicated moderate cognitive impairment. The resident had delusions, verbal aggression and other behaviors directed towards others, and he/she rejected cares for 1-3 of 7 days. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medications during the 7 day observation period.</p> <p>Review of the Cognitive CAA (Care Area Assessment) dated 6/19/2015 documented the resident had inattentiveness, disorganized thinking, and delusions.</p> <p>Review of the Mood and Behavior CAA dated 6/19/2015 documented the resident had bipolar disorder, borderline personality disorder, mild intellectual disability, and depression and took medications to treat the disorders.</p> <p>Review of the care plan dated 11/7/2015 documented the resident sought staff attention and reassurance and had difficulty managing his/her frustration. The resident paced and had inappropriate responses to verbal communication, displayed violent/aggressive behavior towards staff and other residents, and was aggressive at times when he/she had increased anxiety. The care plan directed staff to be patient and calm in response to anger and frustration and assist the resident with coping strategies to include; talking, breathing exercises, walking, and remind the resident of appropriate ways to handle his/her anger.</p>	F 323			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 89</p> <p>Review of an incident investigation documented on 7/18/2015 at 5:12 P.M. the resident became agitated and began yelling in the dining room, which caused resident #84 to yell back. The resident hit resident #84 on the head and resident #84 kicked the resident on his/her arm and leg. The facility reported corrective action taken included; immediate separation and assessment, police notified, increased visual monitoring and staff presence while signs and symptoms of anxiety and aggression were present, staff administered an as needed medication for anxiety and aggression, and the social worker spoke with the resident to ensure physical and emotional well-being and discussed non-violent ways to handle stressful situations.</p> <p>Review of nursing progress notes dated 7/18/2015 lacked documentation of the altercation that occurred on 7/18/2015.</p> <p>Review of the MAR (Medication Administration Record) dated 7/18/2015 revealed the facility lacked documentation that staff administered an as needed medication for anxiety and aggression. Review of social service notes dated 7/18/2015 through 7/20/2015 lacked documentation of the altercations which occurred on 7/18/2015 and lacked discussion between social services and the resident regarding physical and emotional well-being and ways to handle stressful situations.</p> <p>Review of an incident investigation documented on 10/18/2015 at 5:00 P.M. the resident and resident #77 were in the dining room and argued over seating. Resident #77 hit the resident in his/her face twice, which caused swelling to his/her right eye. The facility reported corrective actions taken by the facility included; immediate</p>	F 323			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 90</p> <p>separation and assessment, police notified, increased visual monitoring when in the same areas of the building and signs/symptoms of anxiety and aggression were present, staff administered an as needed medication for pain, physician notified of incident, social worker met with the residents and discussed dining room choices, and dining room rules and etiquette were discussed in the October Resident Council Meeting.</p> <p>Review of nursing progress notes dated 10/18/2015 lacked documentation of the altercation and physician notification of the altercation that occurred on 10/18/2015.</p> <p>Review of the MAR dated 10/18/2015 lacked documentation of staff administered an as needed medication for pain.</p> <p>Review of social service notes dated 10/18/2015 through 10/19/2015 lacked documentation of social service meeting with the resident to discuss dining room choices.</p> <p>Review of October 2015 resident council minutes lacked discussion of dining room rules and etiquette.</p> <p>Review of physician orders dated 10/21/2015 documented an order for an X-ray to the resident's right eye to rule out fracture due to pain. No blowout fracture seen on X-ray dated 10/21/2015.</p> <p>During an observation on 12/09/2015 at 12:12 P.M. the resident sat at the dining room table and interacted appropriately with tablemates and staff.</p> <p>During an observation on 12/09/2015 at 2:58 P.M.</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 91</p> <p>the resident sat at the dining room table alone. He/she was alert, smiled, and interacted with staff and resident as they passed his/her table.</p> <p>During an interview on 12/09/2015 at 2:54 P.M. the resident said there were always fights going on in the dining room. He/she said residents did not like him/her and he/she did not know why. The resident said he/she tells staff when resident #84 threatens him/her and that staff do not care.</p> <p>During an interview on 12/09/2015 at 3:38 P.M. direct care staff Q said the resident and resident #84 did not get along and were verbally and physically abusive towards each other. Staff Q said verbal and physical altercations happen often in the dining room and he/she did not report unless actual physical harm occurred.</p> <p>During an interview on 12/10/2015 at 10:02 A.M. direct care staff R said he/she witnessed resident #84 reach out to strike other resident, but did not report to his/her charge nurse or administration because he/she did not actual hit another resident.</p> <p>During an interview on 12/14/2015 at 8:22 A.M. direct care staff S said the resident and resident #84 had numerous verbal and physical altercations in the past and he/she witnessed resident #84 hit the resident many times. Staff S said he/she heard of an incident when resident #77 hit the resident and the resident got a black eye. Staff S said he/she would let the nurse know of altercations if a resident got hit or hurt.</p> <p>During an interview on 12/14/2015 at 10:41 A.M. licensed nursing staff I said he/she was not aware of any physical altercations between the resident and other residents. Staff I said he/she was told of incidents usually through hearsay and</p>	F 323			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 92</p> <p>sometimes in report, "but not always". Staff I said he/she believed altercations between resident were not communicated appropriately and he/she often heard of resident altercations weeks after altercations occurred.</p> <p>During an interview on 12/15/2015 at 10:19 A.M. licensed nursing staff K said if a resident altercation occurred which had the potential for harm or caused harm he/she would notify the nursing administrator either by phone call or an email and only documented resident to resident altercations in the clinical record if administration told him/her to document.</p> <p>During an interview on 12/14/2015 at 11:41 A.M. social service staff JJ said he/she did not document follow up on the verbal and physical altercation that occurred between the resident and resident #84 according to the facility developed corrective action plan because the altercation was verbal and no one was hurt. Staff JJ said he/she did not document follow up on the verbal and physical altercations between the resident and resident #77 because resident #77 bullied others, the facility had difficult times with him/her, and the facility had already intervened. Staff JJ said he/she did not complete the corrective action interventions and was not always made aware of the facility developed corrective plan interventions.</p> <p>During an interview on 12/15/2015 at 10:38 A.M. administrative nursing staff D said he/she expected staff to report all resident to resident altercations to the immediate supervisor and the immediate supervisor was expected to report the altercation to the administrator. Staff D said he/she expected staff to follow the corrective action plan developed following an altercation and staff were expected follow up and resident response to be documented in the clinical record.</p>	F 323			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 93</p> <p>Staff D said he/she expected the nurses on duty to documentation resident to resident altercations in the clinical record and administer as needed medications as indicated. Staff D said increased visual monitoring consisted of staff being more present in the area. He/she confirmed staff did not document increased visual monitoring and he/she understood the importance of monitoring and documenting the results and effectiveness of increased visual monitoring.</p> <p>During an interview on 12/09/2015 at 4:14 P.M. administrative staff A said he/she did not expect staff to inform him/her of an resident to resident altercations unless a resident was hit or got hurt.</p> <p>Review of the facility's undated Accident and Occurrences policy documented the facility provided adequate supervision to each resident.</p> <p>The facility failed to provide adequate staff supervision to prevent verbal and physical resident to resident altercations.</p> <p>- Review of resident's #6's quarterly Minimum Data Set dated 11/5/15 included the resident scored 7 (severely impaired cognition) on the Brief Interview for Mental Status, had hallucinations (sensing things while awake that appear to be real, but the mind created), delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue), displayed verbal behavioral symptoms directed toward others and other behavioral symptoms not directed toward others 4 to 6 days but less than daily during the 7 day assessment period and ambulated independently in the room/corridor.</p> <p>The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/31/14 included</p>	F 323		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 94</p> <p>the resident had diagnoses of Schizoaffective Disorder (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) which could affect his/her cognition.</p> <p>The resident's Activity of Daily Living CAA dated 12/31/14 included the resident ambulated independently.</p> <p>The resident's Behavioral Symptoms CAA dated 12/31/14 included the resident was physically agitated at times, paced and made physical gestures or was sexually inappropriate. The resident also exhibited verbal outbursts, such as yelling (either when really excited or upset), had rapid speech, or responded inappropriately to questions. The resident's behaviors was difficult to redirect at times and staff currently monitored the resident for physical agitation.</p> <p>Review of a complaint investigation included that on 1/10/15 at approximately 4:30 P.M. resident #29 was in the dining room and spoke to unseen others. Resident #6 was near by and thought resident #29 was speaking to him/her and got agitated and began arguing with the resident. Staff heard the arguing and rushed to the location but before they were able to intervene resident #6 reached out and hit resident #29 in his/her back.</p> <p>The investigation included the facility increased visual monitoring for both residents when the residents exhibited signs/symptoms of anxiety and aggression.</p> <p>The investigation summary included staff</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 95</p> <p>regularly monitored the interventions and adjusted them as needed to minimize the chance of a situation like this happening in the future.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas.</p> <p>Review of a complaint investigation documented on 9/8/15 at approximately 11:45 A.M. the resident became agitated and believed that his/her roommate, resident #75 was talking about him/her. The resident hit resident #75 on the side of his/her head. Staff was near by and immediately intervened by separating the residents and redirected resident #75 away from the area. Resident #6 remained in his/her room and swore and acted aggressive toward staff at which time staff offered and administered the resident an as needed medication for for agitation/anxiety.</p> <p>The investigation included the facility implemented interventions which included staff increased visual monitoring and staff presence for resident #6 when he/she exhibited signs/symptoms of anxiety and aggression.</p> <p>The investigation summary included staff regularly monitored the interventions and adjusted them as needed to minimize the chance of a situation like this from occurring again.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas.</p> <p>Review of a complaint investigation documented</p>	F 323		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 96</p> <p>on 12/3/15 at approximately 3:30 A.M. resident #6 and resident #73 got into an argument near the nurses station. The charge nurse attempted to separate the residents but resident #6 hit the charge nurse on the side of his/her face and pushed resident # 73 which caused the resident to fall to the ground. Resident #73 got himself/herself off of the floor and hollered at resident #6 and staff redirected resident #73 to a chair and redirected resident #6 to his/her room.</p> <p>The investigation included the facility implemented corrective actions which included staff increased visual monitoring for both residents when the residents exhibited signs/symptoms of agitation.</p> <p>On 12/8/15 at approximately 10:05 A.M. a surveyor received permission from the resident to enter his/her room for a resident interview. Observation revealed resident #6 and resident #75 were roommates. During the interview the resident demanded the surveyor look at a photo album and the surveyor explained to the resident he/she would after the interview. The resident became upset, yelled at the surveyor and attempted to hit the surveyor in the head with the album. Staff immediately came to the resident's room and redirected the resident.</p> <p>On 12/9/15 at 8:05 A.M. the resident was in the dining room yelling and nursing administrative staff D stated the resident hit him/her. Staff redirected the resident and the resident yelled at staff to get his/her hands off of him/her.</p> <p>On 12/14/15 at approximately 7:10 A.M. the resident exited his/her room, spoke to the surveyors and ambulated independently to the dining room. As the resident reached the</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 97</p> <p>entrance to the dining room the resident yelled an expletive. Staff escorted the resident to his/her room and the resident yelled get your hands off of him/her.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions.</p> <p>The facility failed to have systems in place to ensure adequate supervision to prevent resident to resident altercations.</p> <p>- Resident #35's electronic medical record included the resident had diagnoses that included Bipolar disorder (major mental illness that caused people to have episodes of severe high and low moods) , Cerebral Palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), Depressive Disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness) and a history of falls.</p> <p>The resident's annual Minimum Data Set dated 10/29/15 identified the resident scored 15 (cognition intact) on the Brief Interview for Mental Status, had hallucinations, delusions, displayed</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 98</p> <p>verbal behavioral symptoms toward others, and other behavioral symptoms not directed toward others 4 to 6 days, but less than daily during the 7 day assessment period. The resident required extensive staff assistance with bed mobility, transfers, locomotion on/off the unit, dressing, toilet use, and personal hygiene and the activity of walking in the room/corridor did not occur. The resident received an antipsychotic and an antidepressant medication 7 of the 7 days during the assessment period.</p> <p>The resident's care plan dated 11/5/15 included staff monitored the resident's behavior for restlessness, hallucinations, yelling and delusions.</p> <p>Review of a complaint investigation with an incident date of 11/19/15 documented that at approximately 1:30 A.M. this resident (#35) and an unsampled residential health care resident (RHC) got into an argument in the dining room because the RHC resident thought resident #35 called him/her names. The RHC resident pushed resident #35's head and kicked his/her chair. Staff was near by and separated the residents.</p> <p>The investigation included the facility implemented the following corrective actions: Staff immediately separated the residents and assessments revealed both resident were free from injury. The facility increased staff presence while the residents were in the same areas of the building and exhibited signs/symptoms of anxiety and aggression. The social worker discussed with both residents non-violent ways to handle stressful situations which could result in acts of aggression/violence. Staff was counseled on proper ways to communicate with resident #35 when he/she experienced delusions. The RHC</p>	F 323		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 99</p> <p>resident was taken to a local hospital for a psychiatric evaluation and he/she later returned to the facility per his/her request.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas.</p> <p>On 12/10/15 at 8:15 A.M. the RHC resident ambulated independently in the facility.</p> <p>On 12/10/15 at 2:30 P.M. resident #35 self propelled his/her wheelchair in the hallways.</p> <p>On 12/10/15 at 1:30 P.M. resident #35 propelled his/her wheelchair down the RHC hall.</p> <p>During Stage 1 of the survey resident #35 reported to a surveyor that approximately a month ago a resident hit him/her and staff was aware of the incident. Resident #35 provided the name of the resident to the surveyor.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she was aware of the incident. Staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions.</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 100</p> <p>The facility failed to have systems in place to ensure adequate supervision to prevent resident to resident altercations.</p> <p>- Review of a complaint investigation with an incident date of 9/6/15 included on 9/6/15 at approximately 4:30 P.M. resident #25 was in the dining room and became agitated. An unsampled Resident Health Care Facility Resident (RHC) told resident #25 to be quiet which started an argument between the 2. The RHC resident walked over to where resident #25 sat and pushed the resident in the head. Staff was near by and immediately intervened and separated the residents.</p> <p>The investigation included the facility implemented corrective actions that included staff increased visual monitoring and staff presence when the residents were in the same area of the building and when the residents showed signs/symptoms of agitation and anxiety.</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas.</p> <p>On 12/10/15 at 8:15 A.M. the RHC resident ambulated independently in the facility.</p> <p>On 12/10/15 at 12:30 resident #25 sat at a dining room table.</p> <p>On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased</p>	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 101</p> <p>monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring.</p> <p>On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions.</p> <p>The facility failed to have systems in place to ensure adequate supervision to prevent resident to resident altercations.</p> <p>- Review of a complaint investigation revealed that on 6/5/15 at approximately 10:20 A.M. resident #25 and resident #84 got into altercation on the back patio of facility. Resident #25 spoke with a staff regarding he/she was not going to take his/her medications until after he/she smoked. Resident #84 told resident #25 to shut up, resident #25 responded by yelling at resident #84 and told him/her to mind his/her own business. Resident #84 then walked over and threw his/her soda on resident #25. As retaliation resident #25 threw his/her cup of water on resident #84 and the residents grabbed at other's clothes and hair. Resident #25 pulled resident's #84's hair and resident #84 hit resident #25 in the groin and the staff intervened and stopped the altercation.</p> <p>The investigation included the facility implemented corrective actions that included staff increased visual monitoring when the resident exhibited signs/symptoms of anxiety and aggression and increased staff presence when the residents were in the same area of the building and exhibited signs/symptoms of anxiety and aggression.</p>	F 323		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 102</p> <p>Review of the resident's clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas.</p> <p>Review of a complaint investigation revealed on 8/24/15 at approximately 1:15 A.M. resident #25 and resident #77 got into a verbal altercation in the dining room. Staff intervened and redirected resident #77 away from the area at which point resident #84 hollered at resident #25 and stated he/she was going to beat him/her. Resident #84 walked over to resident #25 and hit him/her on the side of his/her head. Staff immediately separated the residents and and notified the charge nurse.</p> <p>The investigation included the facility's corrective actions included staff increased visual monitoring and staff presence when the residents exhibited signs/symptoms of anxiety and aggression.</p> <p>Review of the residents clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas.</p> <p>Review of a complaint investigation documented on 10/14/15 at approximately 4:10 P.M. resident #84 walked to the dining room and demanded that resident #11 move out of the chair where he/she sat so he/she could have it, resident #11 responded "no" and told resident #84 that he/she would need to find somewhere else to sit. The residents argued and before staff could intervene resident #84 kicked at resident while he/she was sitting down, in return resident #11 kicked resident #84 which caused him/her to fall back on the ground. Resident #84 got himself/herself up off of the floor, hollered at resident #11 and called</p>	F 323			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 103 the resident names. The investigation included the facility implemented corrective actions that included increased visual monitoring for both residents when the residents exhibited signs/symptoms of anxiety and aggression. Review of the residents' clinical record lacked evidence to support the facility increased staff presence when the residents were in the same areas. On 12/10/15 at 12:30 P.M. resident #84 sat at a dining room table. On 12/14/15 at 9:44 A.M. staff KK stated he/she performed complaint investigations and developed the corrective actions. He/she stated staff JJ was responsible for documenting the results and effectiveness of the corrective actions. Staff KK stated when staff increased monitoring of residents, there was no set frequency and/or duration and the facility did not document the results of the increased monitoring. On 12/14/15 at 12:41 P.M. staff JJ stated he/she did not participate in the complaint investigation and was not always informed of corrective actions. The facility failed to have systems in place to ensure the facility provided adequate supervision to prevent resident to resident altercations.	F 323		
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 104</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This Requirement is not met as evidenced by: The facility reported a census of 80 residents There were 18 residents in the sample. Based on observation interview and record review the facility failed to develop and implement timely and effective interventions to prevent a significant amount of weight loss for 1 of 3 residents reviewed for nutrition (#22) and failed to develop and implement interventions to prevent weight loss for 1 of 3 residents reviewed for nutrition. (#18)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #22's signed physician order sheet dated 12/4/2015 documented the following diagnoses: paranoid schizophrenia (a psychotic disorder characterized by gross distortion of reality), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), depression (an abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), and insomnia (an inability to sleep). Review of the admission MDS (Minimum Data Set) dated 6/26/2015 documented a BIMS (Brief Interview for Mental Status) score of 14, which indicated intact cognition. The resident had hallucinations (seeing and/or hearing things, which were not real), delusions (an untrue 	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 105</p> <p>persistent belief), and mild depression. The resident was independent with eating, weighed 184 pounds, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period.</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 9/24/2015 documented a BIMS score of 15, which indicated intact cognition. The resident had hallucinations, delusions, and moderate depression. The resident was independent with eating with set up assistance from staff, weighed 170 pounds, had no swallowing problems, no significant weight loss over the past 30 to 180 days, and did not receive a therapeutic diet. The resident received 7 days of antipsychotic and antidepressant medication during the 7 day observation period.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 7/1/2015 documented the resident had delusions and hallucinations, paced the halls, and talked to unseen persons on invisible phones.</p> <p>The Nutritional CAA did not trigger for review.</p> <p>Review of the care plan dated 9/24/2015 documented the resident was happy with his/her current weight, wanted to maintain his/her weight, and notified staff if he/she changed his/her mind. The care plan directed staff to provide a double meat sandwich if requested, offer a room tray if he/she did not want to eat in the dining room, provide a regular diet, and assess his/her nutritional status once a year or if his/her condition changed, weigh monthly and as</p>	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 106</p> <p>needed, provide a snack every night before bed, and review nutrition quarterly. The care plan documented the resident slept much of the day, stayed up at night, and missed meals. He/she did not want staff to disturb him/her to ask about meals and would let staff know when he/she wanted to eat.</p> <p>The resident weighed 185 lbs (pounds) on 6/18/2015, 177 lbs on 7/15/2015, which indicated a loss of 4.32% (percent), and 170 lbs on 9/18/2015, which indicated a weight loss of 8.10% over 90 days. The resident weighed 166 lbs on 12/4/2015, which indicated a weight loss of 10.2% in less than 180 days.</p> <p>Review of laboratory results dated 7/2/2015 recorded an albumin (protein in the blood) level of 4.0, which was within normal limits.</p> <p>The facility reported a census of 80 residents There were 18 residents in the sample. Based on observation interview and record review the facility failed to develop and implement timely and effective interventions to prevent a significant amount of weight loss for 1 of 3 residents reviewed for nutrition (#22) and failed to develop and implement interventions to prevent weight loss for 1 of 3 residents reviewed for nutrition. (#18)</p> <p>Review of meal intake records dated November and December 2015 lacked documentation of meal consumption for this resident.</p> <p>Review of a physician order sheet dated 12/4/2015 included the following: Weigh monthly Regular Diet Fluoxetine (a medication used to treat depression, which may decrease appetite) 10 mg</p>	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 107 (milligrams) by mouth daily for depression</p> <p>During an observation on 12/09/2015 at 12:07 P.M. the resident sat at the dining room table and staff served him/her barbeque meatballs, green beans, cake, and juice. The resident ate 100% of meal independently and drank 75% of juice. Staff did not offer the resident more food.</p> <p>During an observation on 12/10/2015 at 7:11 A.M. the resident sat at the dining room table and was served scrambled eggs, French toast sticks with syrup, 2 bowls of cereal with 2 cartons of milk, and sausage links. The resident ate 90% of French toast, 100% of eggs and drank both cartons of meal independently. Staff did not offer the resident more food.</p> <p>During an interview on 12/09/2015 at 3:06 P.M. the resident said he/she lost 12 pounds in the past 2 months and he/she tried to eat more food. The resident said he/she had no appetite and did not try to lose weight.</p> <p>During an interview on 12/09/2015 at 3:36 P.M. direct care staff Q said the resident stayed up late at night, slept a lot during the day, took staff multiple attempts to awaken for supper, and ate well when he/she came out for supper. Staff Q was not sure if the resident lost weight.</p> <p>During an interview on 12/10/2015 at 9 :59 A.M. direct care staff R said the resident was independent with eating. He/she said the resident did not always come out of breakfast, but usually came to the dining room for lunch and usually ate 100%. Staff R said he/she was not sure if the resident lost weight.</p> <p>During an interview on 12/14/2015 at 10:20 A.M.</p>	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 108</p> <p>licensed nursing staff I said the resident was on a regular diet and lost 19 pounds since he/she admitted on June 18, 2015. Staff I said MDS Coordinators tracked weight loss and usually put residents on weekly weights and supplements. Staff I confirmed the resident was not weighed weekly, did not receive a nutritional supplement, and staff did not document meal intake.</p> <p>During an interview on 12/14/2015 at 2:24 P.M. administrative nursing staff E stated he/she was made aware the resident lost weight on 12/13/2015 by dietary staff. He/she confirmed the resident lost a significant amount of weight his/her first 90 days of admission and continued to lose a significant amount of weight. Staff E said he/she revised the resident's care plan on 9/8/2015 and directed staff to remind the resident he/she had sandwiches available if the resident requested. Staff E confirmed the physician and dietitian were not notified of the resident's weight loss.</p> <p>During an interview on 12/10/2015 at 12:15 P.M. dietary staff NN said the resident was on a regular diet, was not on a nutritional supplement, and was not on the sandwich list for bedtime snacks.</p> <p>During an interview on 12/14/2015 at 9:30 A.M. dietary staff FF said he/she was not aware the resident lost a significant amount of weight and he/she was responsible for notifying the dietitian of weight loss.</p> <p>During an interview on 12/15/2015 at 10:55 A.M. administrative nursing staff D said he/she was not aware the resident lost a significant amount of weight, the facility overlooked the resident's weight loss, and staff made him/her aware of the</p>	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 109 weight loss of 12/14/2015.</p> <p>During an interview on 12/15/2015 at 12:21 P.M. dietary consultant GG said he/she was not aware the resident lost a significant amount of weight until he/she received a call yesterday from the facility. Staff GG said he/she expected to notify him/her of the continued weight loss and said he/she would have seen the resident in September if the facility informed him/her of the weight loss.</p> <p>During an interview on 12/15/2015 at 10:05 A.M. physician consultant LL said the facility did not inform him/her of any weight loss since the resident admitted in June of 2015. Staff LL said he/she expected the facility to inform him/her of significant weight loss and said the resident's antidepressant medication, Fluoxetine, was an appetite depressant and may be a contributing factor to the resident's weight loss.</p> <p>Review of the facility's Weight Loss Prevention policy dated 7/14/2015 documented residents with weight loss would have nutritional interventions added as needed and the dietitian would be consulted.</p> <p>The facility failed to timely recognize, develop, and implement interventions to prevent significant weight loss for this resident with a decreased appetite and significant weight loss.</p> <p>- Resident #18's annual Minimum Data Set dated 7/16/15 identified the resident had modified independence cognitively skills for daily decision making, had no behaviors, was independent with eating, weighed 133 pounds, had not experienced</p>	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 110</p> <p>a weight loss and received no nutritional approaches.</p> <p>The resident's Nutritional Care Area Assessment (CAA) dated 7/22/15 included the resident needed encouragement to attend meals due to history of weight fluctuations and the resident's weight had been stable the past 180 days.</p> <p>The resident's care plan with an effective date of 10/14/15 addressed since 1/24/14 the resident's Body Mass Index was 18, the resident's BMI was not high enough, the resident did not want to be on a plan to gain weight but wanted to maintain his/her BMI at 18 or above to maintain his/her health. Staff offered the resident a peanut butter and jelly sandwich every night before he/she went to bed. The resident's nutritional status was assessed at least once a year or he/she had a change in condition and staff reviewed his/her nutritional status every quarter to see if there were any changes. The resident received a regular diet with large portions to help maintain his/her weight. Staff offered the resident a snack of his/her choice each snack time to help maintain his/her weight. Some of the resident's favorite foods included corn and green beans.</p> <p>The resident's care plan did not address the facility educated the resident on the risk and benefits of not receiving all food items or snacks.</p> <p>A Nutritional Assessment completed and signed by a Registered Dietician on 8/7/15 included the resident continued on a regular diet with extra portions to help maintain his/her weight. The resident did not like house shakes and was not interested in receiving them. The resident's weight was stable at 132.2 pounds. The resident's BMI was 18 which was the low end of</p>	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 111</p> <p>the normal range, but the resident was satisfied with his/her current weight and wanted to maintain his/her weight.</p> <p>Review of the resident's weight log revealed the resident's weight ranged from 129 to 132 pounds from 1/3/15 to 12/3/15.</p> <p>Review of the facility's snack roster revealed staff offered the resident a peanut butter and jelly sandwich each night.</p> <p>Review of the resident's clinical record lacked evidence to support staff offered the resident a snack during the morning and evening snack time scheduled at 9:30 A.M. and 3:30 P.M.</p> <p>The resident's electronic physician's orders included on 11/5/15 the resident's physician's gave an order for the resident to receive a regular diet large portions.</p> <p>On 12/9/15 at 12:35 P.M. observation revealed the lunch meal was Ziti, green beans and carrots. Further observation revealed the resident received a double portion of the Ziti, a piece of cake and no green beans or carrots. At 12:45 P.M. the resident had consumed all of the Ziti and the cake and staff did not offer any more of the Ziti, the main entree.</p> <p>On 12/10/15 at 9:45 A.M. staff passed the morning snacks to residents who attended snack time in the dining room. Observation revealed the morning snacks included various food items including cheese curls, fruit and sweet treats such as honey buns. Further observation revealed the resident was not present and there was no evidence to support staff offered the resident the A.M. snacks.</p>	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	Continued From page 112 On 12/10/15 at 12:40 P.M. observation the lunch meal included sloppy joes, hash brown fried potatoes rounds and corn. Further observation revealed the resident received (2) sloppy joes, chocolate pudding and no potatoes or corn. At 12:50 P.M. the resident had consumed both of the sloppy joes and the pudding and staff did not offer the resident more sloppy joes or chocolate pudding. On 12/10/15 at 2:30 P.M. dietary staff FF stated prior to serving residents a meal, staff informed residents of the menu and asked residents what food items he/she would like to be served. The surveyor asked staff FF how the facility made up for the calories the resident missed when he/she did not receive all of the food items on the menu and staff FF stated the resident had a right to choose and refuse which food items he/she did not want. Dietary staff FF confirmed the resident had a physician's order to receive double portions of food at meal times. On 12/15/15 at 9: 00 A.M.. staff R stated the resident did not usually receive a morning snack.. He/she stated staff did not document if the resident was offered a snack nor did staff document the percentage of snacks consumed unless it was a house shake or nutritional supplement. On 12/15/15 at 9:05 A.M. staff H stated the resident usually asked for and received a sandwich in the late evening but the resident did not usually ask for or receive a A.M. or evening snack. He/she stated the facility did not document the percentage of snacks residents received.	F 325			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 325	<p>Continued From page 113</p> <p>On 12/15/15 at 9:35 A.M. and 3:35 P.M. observation revealed staff passed out snacks in the dining room and the resident was not in attendance.</p> <p>On 12/15/15 at 11:28 A.M. nursing administrative staff D stated staff ask residents prior to each meal what he/she wanted. He/she stated the resident tended to choose the main entree and tended to stay away from everything except food items that contained protein and the main entree. Nursing administrative staff D stated staff offered the resident snacks and sandwiches and educated the resident on the risk and benefits of not receiving all food items. He/she stated the resident's care plan should include the education the facility provided the resident regarding his/her nutritional status. Nursing administrative staff D stated the facility offered snacks to all residents but did not document if the resident refused or consumed the snacks.</p> <p>The facility's Weight Loss Prevention Policy and Procedure reviewed 7/14/15 included residents with poor or declining nutritional intake, weight loss, BMI less than 22 and/or pressure ulcers would have nutritional interventions added as needed and the Registered Dietitian would be consulted. Interventions would be added according to resident preferences.</p> <p>The facility failed to offer this resident with a BMI of 18, less than his/her normal range extra servings of the main entree when the resident did not receive all food items included on the daily menu and also failed to have evidence to support the facility offered the resident snacks at each snack time as planned. This practice did not ensure the resident maintained acceptable parameters of nutritional status.</p>	F 325			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 329 F 329 SS=D	Continued From page 114 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 80 residents. The sample was 18 residents, with 5 sampled for medication review. Based on observation, record review, and interview, the facility failed to monitor medications for one (#41) resident. Findings included: - The Physician's Order Sheet (POS) dated 12/4/2015 documented a diagnosis of seizures	F 329 F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 329	<p>Continued From page 115 (violent involuntary series of contractions of a group of muscles). It noted an order for Depakote 1000 milligrams (mg) daily.</p> <p>The Admission Minimum Data Set (MDS) dated 11/17/2015 documented a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment.</p> <p>The Care Area Assessment (CAA) for dated 11/23/2015 for cognitive loss documented the resident was alert and oriented to his/her name and place, was inattentive and had disorganized thinking. He/she needed extra time to answer questions and express his/her thought.</p> <p>The care plan dated 11/11/2015 documented the black box warnings for Depakote.</p> <p>Lab results dated 11/20/2015 noted the valporic acid level of 27 micrograms (ug) per milliliter(ml). The normal level is 50 to 100 ug per ml.</p> <p>Review of the clinical record on 12/10/15, there was not any documentation of physician notification of the low lab result.</p> <p>Observation on 12/09/15 at 12:12 P.M. the resident sat at the dining room table, alert, and interactive with other residents.</p> <p>Interview on 12/10/15 at 10:09 A.M. direct care staff R stated he/she was responsible for documenting simple behaviors and the nurses did more detailed charting.</p> <p>Interview on 12/14/15 at 10:56 A.M. licensed nursing staff I said the physician was notified of abnormal lab results by phone, and was unsure if this specific lab result was relayed to the</p>	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 329	Continued From page 116 physician. Interview on 12/15/15 at 10:33 A.M. administrative nursing staff D said he/she spoke with the nurse practitioner for the psychiatrist (mental illness doctor) and was informed to notify the regular physician. He/she stated when the nurse received the lab, it should of been called to the ordering physician unless otherwise directed. The facility failed to provide a policy about medication monitoring. The facility failed to monitor a medication for seizures for this cognitively impaired resident.	F 329		
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This Requirement is not met as evidenced by: The facility had a census of 80 residents. Based upon record review and interview the facility failed to have a Registered Nurse on duty for at least 8 consecutive hours a day, 7 days a week. Findings included:	F 354		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 354	Continued From page 117 - Review of the facility's December 2015 nursing schedule revealed no Registered Nurse (RN) scheduled on Saturdays and Sundays (12/5, 12/6, 12/12, 12/13, 12/19, 12/20, 12/26 and 12/27). On 12/15/15 at 1:15 P.M. administrative nursing staff D stated a RN worked 10:00 P.M. to 8:00 A.M. on Fridays which provided the facility 8 hours of RN coverage on Saturdays from 12:00 A.M. to 8:00 A.M. Administrative nursing staff D confirmed the facility did not have a RN on duty for at least 8 consecutive hours on Sunday. Administrative nursing staff D stated he/she was unsure how long it had been since the facility had a RN on duty for at least 8 consecutive hours on Sundays. The facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	F 354		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility identified a census of 80 residents. The sample was one main kitchen. Based on observation and interview, the facility failed to prepare, distribute, and serve food under sanitary	F 371		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 371	Continued From page 118 conditions in the main kitchen. Findings included: Observation during the initial tour of the main kitchen on 12/08/2015 at 8:59 A.M. dietary staff DD had facial hair that was not covered. Observation on 12/10/2015 at 11:30 A.M. dietary staff DD and EE had uncovered facial hair. Interview on 12/08/15 at 8:29 A.M. dietary staff DD said facial hair did not need covered unless it was thick. Interview on 12/08/15 at 9:09 A.M. dietary manager FF said there were facial hair guards available and staff were expected to wear them if facial hair was heavy. The facility's policy on Code of Dress and Personal Appearance dated 7/14/2014 documented hairnets, hair restraints, and facial hair guards were worn. The facility failed to prepare, distribute, and serve food under sanitary conditions.	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 387	<p>Continued From page 119</p> <p>This Requirement is not met as evidenced by: The facility had a census of 80 residents. Based upon record review and interview the facility failed to ensure that 3 (#27, #5, #44) of 5 residents sampled for frequency and timeliness of physician visits was seen by a physician at least once every 30 days for the first 90 days after admission, and/or at least once every 60 days thereafter.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #27's clinical record review the resident was admitted to the facility on 7/15/15. Further review revealed the physician saw the resident on 7/30/15, 9/28/15 (a duration of greater than 30 days) and on 11/23 (a duration of greater than 30 days). <p>On 12/15/15 at 3:25 P.M. administrative nursing staff D confirmed the resident did not see the resident every 30 days for the first 90 days of admission.</p> <p>The facility failed to ensure the physician saw the resident at least once every 30 days for the first 90 days after admission.</p> <ul style="list-style-type: none"> - Review of resident #5's electronic health record revealed the resident was admitted to the facility on 7/8/15. Further review revealed the physician saw the resident on 7/10/15, 8/6/15 and on 9/28 (a duration greater than 30 days). <p>On 12/15/15 at 3:25 P.M. administrative nursing staff D confirmed the resident did not see the resident every 30 days for the first 90 days of admission.</p> <p>The facility failed to ensure the physician saw the</p>	F 387			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 387	Continued From page 120 resident at least once every 30 days for the first 90 days after admission. - Review of resident #44's electronic health record revealed the resident was admitted to the facility on 8/20/15. Further review revealed the physician saw the resident on 8/21/15 and on 10/30/15 (a duration greater than 30 days). On 12/15/15 at 3:25 P.M. administrative nursing staff D confirmed the resident did not see the resident every 30 days for the first 90 days of admission. The facility failed to ensure the physician saw the resident at least once every 30 days for the first 90 days after admission.	F 387		
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 reported a census of 80 residents. There were 18 residents in the sample. Based on observation, interview, and record review the facility failed to provide community based mental health services for 1 of 1 residents reviewed for PASRR Level II services (Preadmission Screening and Resident Review)(#6).	F 406		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 121</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of resident #6's signed physician order sheet dated 12/4/2015 documented the following diagnosis: schizoaffective disorder (a mental disorder characterized by abnormal thought processes and deregulated emotions). <p>Review of the admission MDS (Minimum Data Set) dated 12/29/2014 documented a BIMS (Brief Interview for Mental Status) score of 5, which indicated severe cognitive impairment. The resident had hallucinations (seeing or things things not real), delusions (untrue and persistent beliefs), and verbal behaviors directed towards others during the 7 day observation period. He/she did not reject cares. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medication during the 7 day observation period. The resident received no psychotherapy.</p> <p>Review of the quarterly MDS (Minimum Data Set) dated 11/5/2015 documented a BIMS score of 7, which indicated severe cognitive impairment. The resident had hallucinations, delusion, and verbal aggression directed towards others during the 7 day observation period. He/she did not reject cares. The resident received 7 days of antipsychotic, antianxiety, and antidepressant medication during the 7 day observation period. The resident received no psychotherapy.</p> <p>Review of the Cognitive Loss CAA (Care Area Assessment) dated 1/2/2015 documented the resident had a diagnosis of Schizoaffective Disorder and anxiety, which affected his/her cognition. The resident was inattentive with disorganized thinking and he/she lost focus</p>	F 406			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 122 during conversations. The resident had frequent delusions and often stated "I'm dead" despite staff redirection and reorientation, which sometimes led to behavioral issues.</p> <p>Review of the Behavioral Symptoms CAA dated 1/2/2015 documented the resident took scheduled medications for schizoaffective disorder and anxiety and had as needed medications available. The resident became physically agitated at times, paced, and made physical gestures or was sexually inappropriate. He/she had verbal outbursts, rapid speech, and answered questions inappropriately.</p> <p>Review of the care plan 11/6/2015 documented the resident had behaviors and direct staff to notify the physician of increased agitation, avoid redirection when the resident had delusions of being dead, unless the delusions caused him/her increased anxiety.</p> <p>Review of the resident's Level II PASRR dated 6/17/1995 documented the following recommendations: Community based mental health services to monitor mental health needs and a psychiatrist to monitor the mental health illness and psychiatric medications.</p> <p>Review of psychiatrist notes documented visits with medication reviews on 6/18/2015, 8/6/2015, and 11/5/2015.</p> <p>Review of the clinical record dated 10/2014 through 12/2015 revealed the clinical record lacked documentation of participation in a community based mental health center. During an observation on 12/09/2015 at 3:01 P.M. the resident laid in his/her bed, lights out, and</p>	F 406			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 123</p> <p>eyes opened.</p> <p>During an observation on 12/14/2015 at 7:10 A.M. the resident stood at the entrance of the dining room and yelled a curse word at residents seated in the dining room. Staff approached the resident and escorted him/her to his/her room.</p> <p>During an interview on 12/8/2015 at 10:12 A.M. the resident became verbally and physically aggressive. He/she yelled "get out" and attempted to strike the interviewer on the head with a photo album.</p> <p>During an interview on 12/08/2015 at 3:13 P.M. direct care staff Q said "I don't know how many times I've stopped [him/her] from hitting someone." Stated he/she was not sure if the resident received community based mental health services.</p> <p>During an interview on 12/10/2015 at 9:57 direct care staff R said he/she did not know if the resident received community based mental health services.</p> <p>During an interview on 12/14/2015 at 10:23 A.M. licensed nursing staff I said the resident did not receive community based mental health services.</p> <p>During an interview on 12/10/2015 at 5:30 P.M. administrative nursing staff D said the resident did not receive community based mental health services because the resident's insurance did not cover the services.</p> <p>The facility had no policy on rehabilitative services.</p> <p>The facility failed to provide community based mental health services as recommended in the</p>	F 406			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 124 PASRR for this resident who had a diagnosis of schizoaffective disorder with verbal and physical aggression.	F 406		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This Requirement is not met as evidenced by: The facility had a census of 80 residents. Based upon observation, record review and interview the facility failed to provide dental services for 1 (#46) of 3 residents sampled for dental services. Findings included: - Resident #46's Quarterly Minimum Data Set (MDS) dated 11/23/15 identified the resident scored 14 (cognition intact) on the Brief Interview for Mental Status (BIMS), was independent with eating, weighed 231 pounds and had not experienced a weight loss. The resident's admission MDS dated 5/20/15 identified the resident scored 10 (moderately impaired cognition) on the BIMS, was independent with eating, weighed 232 pounds, had no natural teeth or tooth fragments. The resident's care plan reviewed 11/25/15	F 412		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 412	<p>Continued From page 125</p> <p>included since 5/20/15 the resident's care plan addressed the resident did not have natural teeth. The resident had dentures but preferred not to wear them. Since the resident did not wear his/her dentures, staff sometimes altered some of the texture of the resident's food to allow the resident to eat. If the resident said he/she wanted something to eat that might seem difficult to eat, staff reminded the resident of this but staff remembered the resident had eaten without dentures for some time and knew the foods he/she could eat. The licensed nurse checked the resident's mouth and teeth each month and any time the resident complained of mouth discomfort.</p> <p>Review of the resident's weights from 5/20/15 to 12/9/15 revealed the resident's weight averaged 234 pounds.</p> <p>A nurse's note (NN) dated 11/23/15 and timed 2:34 P.M. included the resident received a regular diet, occasionally complained of problems with chewing related to being edentulous.</p> <p>The resident's Oral Assessment dated 6/17/15 included the resident denied any problems with chewing/swallowing but was able to have mechanical soft diet upon request. The resident want to speak with the dentist about dentures. Staff would refer the resident to see the in house dentist.</p> <p>The resident's Oral Assessment dated 11/18/15 included the resident was edentulous (no natural teeth) and did not have dentures.</p> <p>The resident's Nutrition Assessment dated 6/3/15 included the resident had no natural teeth, was edentulous and chose not to wear dentures.</p>	F 412		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 412	<p>Continued From page 126</p> <p>The documentation on the resident's Dental Exam/Treatment note dated 7/29/15 was illegible.</p> <p>On 12/9/15 at 12:45 P.M. the resident sat at a dining room table and ate his/her lunch meal which consisted of Ziti, carrots and green beans. At 12:55 P.M. the resident had consumed 50 percent (%) of the Ziti, none of the carrots or green beans. The resident stated since he/she did not have teeth it was difficult for him/her to eat the vegetables. At 1:05 P.M. the resident had consumed 76% of the Ziti and none of the vegetables. At 1:15 P.M. the resident stated he/she ate 1 or 2 of the carrots and green beans because it was difficult for him/her to chew without teeth.</p> <p>On 12/10/15 at 7:45 A.M. the resident sat at a dining room table and ate French toast sticks with syrup, ground sausage and eggs. At 8:15 A.M. the resident had consumed 100% of the food.</p> <p>On 12/8/15 at 10:34 A.M. the resident stated he/she saw the dentist in July. He/she stated he/she wanted dentures, he/she would require some dental work prior to receiving dentures. He/she stated it was some issues with insurance/money as to why she had not received dentures and staff had not responded back to him/her regarding his/her request for dentures.</p> <p>On 12/9/15 at 2:55 P.M. staff JJ stated he/she did not know if the resident had dentures or not. He/she stated he/she arranged dentist appointments and assisted residents with obtaining dentures.</p> <p>On 12/9/15 at approximately 4:30 P.M. staff G stated the resident saw the dentist on 7/24/15</p>	F 412			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 412	<p>Continued From page 127</p> <p>and the dentist documented the resident had root tips, would need to have some dental work if the resident prior to receiving dentures and the resident did not want to have the work performed. The staff confirmed the resident's care plan addressed the resident had dentures.</p> <p>On 12/10/15 at 8:30 A.M. dentist MM stated he/she did not know if he/she had seen the resident. Dentist MM stated the resident was not on the dental program and he/she would contact the surveyor regarding the July 2015 visit.</p> <p>On 12/10/15 dentist MM stated he/she saw the resident on 7/24/15, the resident had root tips and if the resident wanted dentures the resident needed some work to prepare for the dentures. Dentist MM stated at that time the resident was new to the facility and it was his/her opinion the facility just wanted him/her to look and see what the resident's oral cavity looked like. Dentist MM stated he/she did not know if the resident still resided in the facility and no one had asked him/her to see the resident after that date.</p> <p>The resident's clinical record lacked evidence the facility had spoken to the resident regarding dentures since he/she the dentist on 7/24/15.</p> <p>On 12/15/15 at 9:08 A.M. staff H stated the resident had expressed concerns about able to chew snacks/foods and he/she informed the resident the facility could change the texture of the food. Staff H stated the resident asked about dentures and he/she passed the information on the staff JJ. Staff H stated stated he/she thought due to insurance issues and the length of time the resident resided in the facility the resident had not received dentures.</p>	F 412			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 412	Continued From page 128 The facility's Dental Services Policy and Procedure included it was the facility's policy to provide or obtain dental services to meet the needs of each resident. Routine and emergency dental services were available and was available to meet the resident's oral health needs. The facility failed to follow up with this resident in a timely manner regarding his/her request for dentures.	F 412		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This Requirement is not met as evidenced by: The facility identified a census of 80. Based on observation, interview, and record review, the facility's administration failed to manage the facility in a manner to meet the needs of all residents. Findings included: - The facility's administration failed to manage the facility in a manner to meet the needs of the resident's, as evidenced by the following citations: Based on observation, interview, and record review, the facility's administration failed to address the timely notify the physician of this resident's significant weight loss. Please refer to F157. Based on observation, interview, and record review, the facility's administration failed to address providing quarterly statements about the	F 490		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 490	<p>Continued From page 129</p> <p>residents' funds accounts. Please refer to F159. Based on observation, interview, and record review, the facility's administration failed to address the release funds after death for this resident. Please refer to F160.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address systems in place to ensure all staff were informed of corrective actions implemented after resident to resident abuse. The facility also failed to have systems in place to ensure corrective actions were implemented and monitored to prevent further occurrences from happening. Please refer to F223.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address the follow through on facility developed corrective action interventions and protect resident #30 from verbal and physical abuse on 2 occasions of resident to resident altercations. Please refer to F223.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address the investigating and reporting to the State Survey Agency an allegation of resident to resident abuse. Please refer to F225.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address the investigation of a verbal and physically threatening altercation between this resident and resident #84 who had previous verbal and physical altercations in the past. Please refer to F225.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address providing bathing preference. Please refer to F242.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address having systems in place to ensure</p>	F 490			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 490	<p>Continued From page 130</p> <p>residents received medically related social service to meet the residents' mental and psychosocial needs. Please refer to F250. Based on observation, interview, and record review, the facility's administration failed to address providing sufficient social services to ensure this resident received the care and services needed to manage his/her behaviors. Please refer to F250.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address recognizing and conducting a timely comprehensive significant change in status assessment for this resident who experienced a significant weight loss and increased depression. Please refer to F274.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address reviewing and revising the care plan for this resident who had a significant weight loss. Please refer to F280.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address determining the resident's preference regarding the resident's chin hairs. This practice placed this resident at risk for not being properly groomed. Please refer to F311.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address providing Activities of Daily Living (ADLs) shaving assistance for this resident who required staff supervision with shaving. Please refer to F311.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address providing incontinence care to this cognitively impaired resident. Please refer to F315.</p> <p>Based on observation, interview, and record review, the facility's administration failed to</p>	F 490			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 490	<p>Continued From page 131</p> <p>address having systems in place to ensure the facility provided adequate supervision to prevent resident to resident altercations. Please refer to F323.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address providing adequate staff supervision to prevent verbal and physical resident to resident altercations. Please refer to F323.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address offering this resident with a Body Mass Index (BMI) of 18, less than his/her normal range extra servings of the main entree when the resident did not receive all food items included on the daily menu and also failed to have evidence to support the facility offered the resident snacks at each snack time as planned. This practice did not ensure the resident maintained acceptable parameters of nutritional status. Please refer to F325.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address timely recognizing, developing, and implementing interventions to prevent significant weight loss for this resident with a decreased appetite and significant weight loss. Please refer to F325.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address monitoring a medication for seizures for this cognitively impaired resident. Please refer to F329.</p> <p>Based on observation, interview, and record review, the facility's administration failed to address using the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Please refer to F354.</p> <p>Based on observation, interview, and record review, the facility's administration failed to</p>	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 490	Continued From page 132 address preparing, distributing, and serving food under sanitary conditions. Please refer to F371. Based on observation, interview, and record review, the facility's administration failed to address ensuring the physician saw the resident at least once every 30 days for the first 90 days after admission. Please refer to F387. Based on observation, interview, and record review, the facility's administration failed to address providing community based mental health services as recommended in the Pre-Admission Screening and Resident Review (PASRR) for this resident who had a diagnosis of schizoaffective disorder with verbal and physical aggression. Please refer to F406. Based on observation, interview, and record review, the facility's administration failed to address following up with this resident in a timely manner regarding his/her request for dentures. Please refer to F412. Based on observation, interview, and record review, the facility's administration failed to address completing yearly performance reviews for direct care staff. Please refer to F497. Based on observation, interview, and record review, the facility's administration failed to address maintaining complete and accurate medical records, including multiple resident to resident abuse with injury and non-injury, failed to document measurable interventions for each of the residents, and failed to provide documentation of assessments after these resident to resident abuse altercations occurred. Please refer to F514. The facility's administration failed to manage the facility in a manner to meet the needs of all residents.	F 490			
F 497 SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 497	<p>Continued From page 133</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 80 residents. The sample was 3 personnel records of direct care staff. Based on record review and interview, the facility failed to complete a yearly performance review for direct care staff O, P, and U.</p> <p>Findings included:</p> <p>Review of the personnel record for direct care staff O revealed he/she was hired 8/29/14 and the facility lacked documentation of an annual performance review.</p> <p>Review of the personnel record for direct care staff P revealed he/she was hired 7/2/12 and the facility lacked documentation of an annual performance review.</p> <p>Review of the personnel record for direct care staff U revealed he/she was hired 2/19/13 and the facility lacked documentation of an annual performance review.</p>	F 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 497	Continued From page 134 Interview on 12/15/15 at 1:54 P.M. administrative nursing staff D said the facility does not complete direct care staff performance reviews. The facility failed to provide a policy regarding direct care staff annual performance reviews and other training as requested. The facility failed to complete yearly performance reviews for direct care staff.	F 497		
F 514 SS=C	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This Requirement is not met as evidenced by: The facility identified a census of 80 residents. Based on observation, record review, and interview, the facility failed to maintain accurate and readily accessible clinical records. Findings included: - Interview on 12/7/15 at 9:00 A.M. administrative nursing staff D stated the resident's current care plan and weights were in the medical record.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 514	<p>Continued From page 135</p> <p>Review of the clinical record on 12/9/15 for resident #58 identified by staff to have falls, lacked any documentation.</p> <p>Observation on 12/9/15 administrative nursing staff D retrieved the fall information from his/her locked office.</p> <p>Interview on 12/9/15 at 2:30 P.M. administrative nursing staff D confirmed the fall information was part of the resident's clinical record.</p> <p>Review of the facility's abuse investigation dated 7/18/15, resident #30 hit resident #84, who hit him/her back.</p> <p>Review of the facility's abuse investigation dated 10/18/15, resident #77 hit resident #30, who sustained an injury to his/her eye.</p> <p>Review of the facility's abuse investigation dated 11/19/15, an unsampled resident hit resident #35 in the head.</p> <p>Review of the clinical record on 12/14/15 for residents #30, #35, #77, and #84 lacked documentation about resident to resident physical contact and any interventions the facility provided.</p> <p>Interview on 12/14/15 at 12:31 P.M. social services staff JJ stated he/she only documented in the clinical record about resident to resident physical contact when there was an injury.</p> <p>Interview on 12/14/15 at 2:25 P.M. licensed nursing staff J stated he/she only documented in the clinical record about resident to resident physical contact when there was an injury.</p>	F 514		

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 514	Continued From page 136 Interview on 12/15/15 at 10:19 A.M. licensed nursing staff stated he/she documented in the clinical record about resident to resident physical contact if he/she was instructed to do so. The facility failed to provide a policy about medical records. The facility failed to maintain complete and accurate medical records, including multiple resident to resident abuse with injury and non-injury, failed to document measurable interventions for each of the residents, and failed to provide documentation of assessments after these resident to resident abuse altercations occurred.	F 514		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 520	<p>Continued From page 137</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This Requirement is not met as evidenced by: The facility identified a census of 80 residents. The sample included 18 residents. Based on record review and interview, the facility Quality Assessment and Assurance (QAA) committee failed to identify and remedy issues that required an action plan.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - The facility failed to ensure the QAA committee addressed the timely notify the physician of this resident's significant weight loss. Please refer to F157. The facility failed to ensure the QAA committee addressed provide quarterly statements about the residents' funds accounts. Please refer to F159. The facility failed to ensure the QAA committee addressed release funds after death for this resident. Please refer to F160. The facility failed to ensure the QAA committee addressed systems in place to ensure all staff were informed of corrective actions implemented after resident to resident abuse. The facility also failed to have systems in place to ensure corrective actions were implemented and monitored to prevent further occurrences from happening. Please refer to F223. The facility failed to ensure the QAA committee addressed the follow through on facility developed corrective action interventions and protect resident #30 from verbal and physical abuse on 2 occasions of resident to resident altercations. Please refer to F223. The facility failed to ensure the QAA committee 	F 520			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 520	<p>Continued From page 138</p> <p>addressed the investigating and reporting to the State Survey Agency an allegation of resident to resident abuse. Please refer to F225.</p> <p>The facility fail to ensure the QAA committee addressed the investigation of a verbal and physically threatening altercation between this resident and resident #84 who had previous verbal and physical altercations in the past. Please refer to F225.</p> <p>The facility failed to ensure the QAA committee addressed providing bathing preference. Please refer to F242.</p> <p>The facility failed to ensure the QAA committee addressed having systems in place to ensure residents received medically related social service to meet the residents' mental and psychosocial needs. Please refer to F250.</p> <p>The facility failed to ensure the QAA committee addressed providing sufficient social services to ensure this resident received the care and services needed to manage his/her behaviors. Please refer to F250.</p> <p>The facility failed to ensure the QAA committee addressed recognizing and conducting a timely comprehensive significant change in status assessment for this resident who experienced a significant weight loss and increased depression. Please refer to F274.</p> <p>The facility failed to ensure the QAA committee addressed reviewing and revising the care plan for this resident who had a significant weight loss. Please refer to F280.</p> <p>The facility failed to ensure the QAA committee addressed determining the resident's preference regarding the resident's chin hairs. This practice placed this resident at risk for not being properly groomed. Please refer to F311.</p> <p>The facility failed to ensure the QAA committee addressed providing Activities of Daily Living (ADLs) shaving assistance for this resident who</p>	F 520			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 520	<p>Continued From page 139</p> <p>required staff supervision with shaving. Please refer to F311.</p> <p>The facility failed to ensure the QAA committee addressed providing incontinence care to this cognitively impaired resident. Please refer to F315.</p> <p>The facility failed to ensure the QAA committee addressed having systems in place to ensure the facility provided adequate supervision to prevent resident to resident altercations. Please refer to F323.</p> <p>The facility failed to ensure the QAA committee addressed providing adequate staff supervision to prevent verbal and physical resident to resident altercations. Please refer to F323.</p> <p>The facility failed to ensure the QAA committee addressed offering this resident with a Body Mass Index (BMI) of 18, less than his/her normal range extra servings of the main entree when the resident did not receive all food items included on the daily menu and also failed to have evidence to support the facility offered the resident snacks at each snack time as planned. This practice did not ensure the resident maintained acceptable parameters of nutritional status. Please refer to F325.</p> <p>The facility failed to ensure the QAA committee addressed timely recognizing, developing, and implementing interventions to prevent significant weight loss for this resident with a decreased appetite and significant weight loss. Please refer to F325.</p> <p>The facility failed to ensure the QAA committee addressed monitoring a medication for seizures for this cognitively impaired resident. Please refer to F329.</p> <p>The facility failed to ensure the QAA committee addressed using the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Please refer to F354.</p>	F 520			

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

Printed: 12/22/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 17E528	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/22/2015
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 440 SE WOODLAND AVE TOPEKA, KS 66607		
(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 520	<p>Continued From page 140</p> <p>The facility failed to ensure the QAA committee addressed preparing, distributing, and serving food under sanitary conditions. Please refer to F371.</p> <p>The facility failed to ensure the QAA committee addressed ensuring the physician saw the resident at least once every 30 days for the first 90 days after admission. Please refer to F387.</p> <p>The facility failed to ensure the QAA committee addressed providing community based mental health services as recommended in the Pre-Admission Screening and Resident Review (PASRR) for this resident who had a diagnosis of schizoaffective disorder with verbal and physical aggression. Please refer to F406.</p> <p>The facility failed to ensure the QAA committee addressed following up with this resident in a timely manner regarding his/her request for dentures. Please refer to F412.</p> <p>The facility failed to ensure the QAA committee addressed completing yearly performance reviews for direct care staff. Please refer to F497.</p> <p>The facility failed to ensure the QAA committee addressed maintaining complete and accurate medical records, including multiple resident to resident abuse with injury and non-injury, failed to document measurable interventions for each of the residents, and failed to provide documentation of assessments after these resident to resident abuse altercations occurred. Please refer to F514.</p> <p>The facility failed to have an effective QAA program in place to monitor and implement corrective actions for issues identified.</p>	F 520			