

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

Printed: 12/10/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>17E613</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>12/10/2015</b>
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NAME OF PROVIDER OR SUPPLIER <b>LOGAN COUNTY MANOR - LTCU</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>615 PRICE AVE OAKLEY, KS 67748</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This Requirement is not met as evidenced by: The facility had a census of 37 residents. The sample included 3 residents, which were reviewed for falls. Based on observation, interview, and record review the facility failed to ensure staff implemented interventions, as care planned, for 1 of 3 sampled residents, and the resident continued to fall. (#2).</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #2's admission (MDS) Minimum Data Set assessment, dated 7/30/15, indicated the resident was cognitively intact with a (BIMS) Brief Interview for Mental Status score of 14, demonstrated wandering behaviors, and required limited assistance of 1 staff for his/her (ADLs) Activities of Daily Living. The MDS further indicated the resident had an unsteady balance, but was able to stabilize without staff assistance, had no falls, and received antidepressant and diuretic medications.</li> </ul> <p>The 8/18/15 care plan informed staff the resident was a high risk for falls and instructed staff to</p>	F 323		

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

TITLE

(X6) DATE

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

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F 323	<p>Continued From page 1</p> <p>provide stand by assistance with transfers and ambulation, ensure the resident is wearing appropriate footwear, and to provide a prompt response to all requests for assistance. The care plan further instructed staff to provide a personal alarm and ensure the device was in place as needed. The 10/4/15 care plan update instructed staff to ensure the personal alarm was in place when he/she was in bed. The 11/17/15 care plan update indicated the need to educate staff of the importance of alarm placement.</p> <p>The 7/23/15 fall risk assessment indicated the resident was a high risk for falls.</p> <p>The 10/4/15 at 7:25 AM, nurse's note indicated staff found the resident on his/her knees in the bathroom. The note indicated the resident stated he/she had gotten up to go to the bathroom, and did not call for assistance. The note further indicated the bed alarm was in place, plugged in, and turned on, but was not activated, so staff did not hear the alarm. The note indicated the resident had sustained no injury from the fall.</p> <p>The 11/17/15 at 11:01 AM, nurse's note indicated staff found the resident on the floor, lying on his/her right side. The note further indicated that the personal alarm was not active or connected properly at the time of the incident. The note indicated the resident sustained a bruise to his/her knee.</p> <p>On 12/8/15 at 4:20 PM, observation revealed the resident seated in his/her recliner with his/her feet elevated, call light within reach, and a personal alarm in place. Further observation revealed staff entered the room to assist the resident with toileting. Continued observation revealed staff asked the resident if he/she needed to use the</p>	F 323			

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F 323	<p>Continued From page 2</p> <p>toilet, lowered his/her feet, applied a gait belt, and assisted the resident to stand with his/her walker. Further observation revealed as the resident stood, the personal alarm sounded and was turned off by staff, and the resident ambulated to the bathroom with assistance of the staff. Observation revealed the resident was assisted to sit in his/her wheelchair with a personal alarm in place, and staff propelled him/her to the dining room for the evening meal.</p> <p>On 12/8/15 at 4:31 PM, Nurse Aide A verified staff had to make sure the resident's bed and chair alarms were on when the resident was in his/her room. Nurse Aide A stated the resident has had a cognitive and physical decline recently, and staff have to check on him/her often.</p> <p>On 12/8/15 at 3:43 PM, Nurse B verified staff have to connect the resident's personal alarm into the call light system, so when the resident attempts to get up, staff are notified through the system. Nurse B further verified the resident had gotten out of bed, his/her alarms were not connected properly and he/she had a fall, and staff have been educated about the alarms.</p> <p>On 12/9/15 at 1:30 PM, Administrative Nurse C verified the resident had 2 falls related to the personal alarms not connected properly.</p> <p>The facility failed to ensure placement of Resident #2's personal alarms, as care planned, to alert the staff when the resident got out of bed, and the resident had 2 falls.</p>	F 323			