

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

PRINTED: 04/05/2016  
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  <b>04/05/2016</b>
--	---	--	---

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>
--	--

(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  The following citations represent the findings of a Health Resurvey.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  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).  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.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	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.

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  <b>04/05/2016</b>
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>		
(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>This REQUIREMENT is not met as evidenced by:</p> <p>The facility had a census of 36 residents. Based on observation, record review ad interview the facility failed to obtain physician ordered medication in a timely manner for 1 of the 5 residents reviewed for unnecessary medications. (#30)</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #30's significant change (MDS) Minimum Data Set assessment, dated 8/05/2015, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment, The MDS indicated the resident received antipsychotic and antidepressant medications.</li> </ul> <p>The 8/05/2015 mood state and cognitive loss (CAA) Care Area Assessment summary indicated the resident received Seroquel (antipsychotic medication), and Cymbalta (antidepressant medication).</p> <p>The 7/30/2015 care plan directed the staff to administer medications as per physician ordered and to monitor for side effects and effectiveness. The care plan directed the staff to discuss with the physician the ongoing need for the medications.</p> <p>The 10/01/2015 physician order directed the staff to administer, to the resident, the following medications: Seroquel, 25 mg (milligram), at bedtime. Cymbalta, 30 mg, a day. Lovastin, (a medication used to lower cholesterol)</p>	F 157			

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  <b>04/05/2016</b>
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>		
(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>10 mg, a day Maalox suspension, (a medication use to relieve stomach acidity) 10 (ml) milliliters, before meals and at bedtime.</p> <p>Review of the October 2015 (MAR) Medication Administration Record and nurse's notes revealed no documentation the resident received the following medications on the following dates in October 2015: Seroquel, 25 mg, 10/20/15 and 10/21/2015. (2 days) Cymbalta, 30 mg, 10/19,15, 10/20,15, and 10/21/15. (3 days) Lovastin, 10 mg, 10/20/15, and 10/21/2015. (2 days) Maalox suspension, 10 ml, the 5:00 PM dose, on 10/ 05/15, 10/06/15, 10/16/15, 10/20/15, 10/26/15, and 10/28/15. (6 doses)</p> <p>On 3/30/2016 at 8:45 AM, observation revealed the resident transferred from his/her bed to the wheelchair with assistance of 1 staff. Continued observation revealed the resident propelled his/her wheelchair to the toilet and ignored staff assistance and direction.</p> <p>The 2/2010 the Logan County Manor and Resident Right policy indicated the facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative and/or family member when there is a need to alter treatment significantly, or to commence a new form of treatment.</p> <p>On 3/31/2016 at 10:30 AM, Administrative Nurse C verified staff had not administered the</p>	F 157			

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

PRINTED: 04/05/2016  
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  <b>04/05/2016</b>
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>		
(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 3 physician ordered Seroquel, Cymbalta, Lovastin, and Maalox, as noted on the MAR. He/she had not been informed by staff the medication was not available to administer. Administrative Nurse C stated the residents family would bring some of his/her medication to the facility to administer, but was unsure if that was the situation. Administrative Nurse C verified the physician had not been informed the resident did not receive the physician ordered medications in October.	F 157			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 8 residents. Based on observation, record review and interview the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each residents dignity, for 3 of 36 residents on 3 days of the survey. (#19,#4,#3)  Findings included:  - On 3/29/16 at 8:10 AM, observation revealed	F 241			

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

PRINTED: 04/05/2016  
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  <b>04/05/2016</b>
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>		
(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 241	<p>Continued From page 4</p> <p>Resident #19 seated in his/her wheelchair, at the dining table, eating breakfast. Further observation revealed 5 other residents in wheelchairs at the same dining table. Continued observation revealed Nurse A obtaining Resident #19's blood pressure (a machine used to measure the force and rate of the heartbeat) at the table then verbalizing the result of the blood pressure.</p> <p>On 3/30/16 at 8:10 AM, observation revealed Resident #19 seated in his/her wheelchair, at the dining table, eating breakfast. Further observation revealed 5 other residents seated in wheelchairs at the same dining table. Continued observation revealed Nurse A obtaining Resident #19's blood pressure at the table.</p> <p>On 3/30/16 at 11:30 AM, observation revealed Resident #4 seated in his/her wheelchair at the dining table. Further observation revealed 4 other residents seated at the same table. Continued observation revealed Nurse B asking Resident #4 if he/she had pain in his/her shoulder and if he/she needed to see the physician.</p> <p>On 3/30/16 at 11:45 AM, observation revealed Resident #3 seated in his/her wheelchair, at the dining table, eating his/her lunch. Further observation revealed 3 other residents seated at the same table. Continued observation revealed Nurse B placing a pulse oximeter (used to measure the oxygen saturation in the blood) on the resident's index finger.</p> <p>On 3/31/16 at 8:50 AM, observation revealed Resident #3 seated in his/her wheelchair at the dining table. Further observation revealed 4 other residents seated at the same dining table. Continued observation revealed Nurse B placing</p>	F 241			

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

PRINTED: 04/05/2016  
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  <b>04/05/2016</b>
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>		
(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 241	Continued From page 5 a pulse oximeter on the resident's index finger.  On 3/31/16 at 9:10 AM, Nurse B verified he/she was unsure if resident blood pressures or pulse oximeters should be done at the dining table during meals.  On 3/31/16 at 9:20 AM, Administrative Nurse C verified resident blood pressures or pulse oximeters should not be taken at the dining table and this was a dignity concern.  The 2/2010 facility policy for dignity states the facility must promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality.  The facility failed to provide dignity for Residents #19, #4 and #3 when staff obtained blood pressures or oxygen saturation levels or discussed medical condition at the dining table during meals.	F 241			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425			

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

PRINTED: 04/05/2016  
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  <b>04/05/2016</b>
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>		
(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 425	<p>Continued From page 6 the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. Based on observation, record review and interview the facility failed to obtain physician ordered medication in a timely manner for 1 of the 5 residents reviewed for unnecessary medications. (#30)</p> <p>Findings included:</p> <ul style="list-style-type: none"> <li>- Resident #30's admission (MDS) Minimum Data Set assessment, dated 8/05/2015, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment, The MDS indicated the resident received antipsychotic and antidepressant medications.</li> </ul> <p>The 8/05/2015 mood state and cognitive loss (CAA) Care Area Assessment summary indicated the resident received Seroquel (antipsychotic medication), and Cymbalta (antidepressant medication).</p> <p>The 7/30/2015 care plan directed the staff to administer medications as per physician orders and to monitor for side effects and effectiveness. The care plan directed the staff to discuss with</p>	F 425			

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

PRINTED: 04/05/2016  
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  <b>04/05/2016</b>
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>		
(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 425	<p>Continued From page 7</p> <p>the physician the ongoing need for the medications.</p> <p>The 10/01/2015 physician order directed the staff to administer, to the resident, the following medications: Seroquel, 25 mg (milligram), at bedtime. Cymbalta, 30 mg, a day. Lovastin, (a medication used to lower cholesterol) 10 mg, a day Maalox suspension, (a medication use to relieve stomach acidity) 10 (ml) milliliters, before meals and at bedtime.</p> <p>Review of the October 2015 (MAR) Medication Administration Record and nurse's notes revealed no documentation the resident received the following medications on the following dates in October 2015: Seroquel, 25 mg, 10/20/15 and 10/21/2015. (2 days) Cymbalta, 30 mg, 10/19,15, 10/20,15, and 10/21/15. (3 days) Lovastin, 10 mg, 10/20/15, and 10/21/2015. (2 days) Maalox suspension, 10 ml, the 5:00 PM dose, on 10/ 05/15, 10/06/15, 10/16/15, 10/20/15, 10/26/15, and 10/28/15. (6 doses)</p> <p>On 3/30/2016 at 8:45 AM, observation revealed the resident transferred from his/her bed to the wheelchair with assistance of 1 staff. Continued observation revealed the resident propelled his/her wheelchair to the toilet and was impulsive and ignored staff assistance and direction.</p> <p>The 8/07/2016 Ordering and Receiving policy indicated medications and related products are received from the pharmacy supplier on a timely</p>	F 425			

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

PRINTED: 04/05/2016  
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  <b>04/05/2016</b>
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>		
(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 425	<p>Continued From page 8</p> <p>basis. The facility maintains accurate records of medications ordered and receipt. The policy indicated repeat medications (refills) from all other pharmacies besides the adjacent hospital pharmacy, are ordered three to four days in advance of need to assure and adequately supply is on hand. The policy stated when ordering medications that require special processing, order at least seven days in advance of need.</p> <p>On 3/31/2016 at 10:30 AM, Administrative Nurse C verified staff had not administered the physician ordered Seroquel, Cymbalta, Lovastin, and Maalox, as noted on the MAR. He/she had not been informed by staff the medication was not available to administer. Administrative Nurse C stated the residents family would bring some of his/her medication to the facility to administer, but was unsure if that was the situation.</p> <p>The facility failed to obtain/administer the physician ordered medications for administration to Resident #30 in a timely manner.</p>	F 425			