STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E528	A. BUILDING _____ B. WING _____	01/10/2022

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

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint #KS00167860. The 2567 was electronically sent to the facility on 01/13/22.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: The facility had a census of 87 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to provide the necessary services to maintain activities of daily living (ADLs) for two sampled residents, Resident (R)71 and R78. This placed the residents at risk for poor hygiene and decline in ADLs. Findings included: - R71's "Physician Order Sheet" (POS), dated 12/06/21, documented diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body) following a cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) affecting right dominant side, restlessness and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition), and dementia (progressive mental disorder characterized by failing memory,	F 677		

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 677	Continued From page 1	F 677		

confusion) with behavioral disturbance.

The "Annual Minimum Data Set" (MDS), dated 12/09/21, documented the resident had moderately impaired cognition, wandering, and required extensive assistance of one staff for transfers, dressing, personal hygiene, and bathing. The resident had range of motion impairment to upper and lower extremities of one side and used a wheelchair for mobility. The MDS further documented it was very important for R71 to choose between a bath, shower, bed bath, or sponge bath.

The "ADL Care Area Assessment" (CAA), dated 12/13/21, documented the resident had hemiplegia related to a stroke and had ADL deficits which required assistance of staff.

The "Care Plan," dated 12/22/21, documented R71 had hemiplegia affecting his dominant side, needed assistance with most ADL cares, needed increased toileting plan to include before and after meals or every two to three hours while awake due to receiving a diuretic (medication to promote the formation and excretion of urine). The "Care Plan" documented R71 required assistance for cutting up food, used large handled utensils, and directed staff to provide non-medication pain relief measures such as positioning and warm shower. The resident's bathing choice was Monday, Wednesday, and Friday.

The "Restorative Progress Note" dated 01/04/22, documented R71 required limited to extensive assistance with ADL's, wore adult incontinence briefs, and was checked and changed every two hours and as needed.

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F 677	Continued From page 2	F 677		

The "MDS Progress Note" dated 12/10/21, documented R71 had a history of stroke with dominant side hemiplegia, had a toileting program by staff upon waking, before and after meals, and at bedtime. The note further documented the resident's regular diet was served on a divided plate with large handled utensils and he ate at the restorative table for monitoring and assistance with cutting his foods. The note also documented the need of one staff for personal hygiene, dressing, and showering.

Review of the "Bathing Record" for R71 revealed the resident had no recorded bathing from 11/01/21 until (resident refused on 11/05/21) 11/17/21 (17 days). Further review of December 21 through January 10, 22 lacked documentation the resident had received or refused bathing (54 days).

On 01/05/21 at 08:34 AM, observation revealed R71 sat in the dining room, in a wheelchair, and received medications from the nurse.

On 01/05/21 at 11:52 AM, observation revealed the resident remained in the dining room, and had not been removed or offered toileting assistance. Meal service had started and he eaited to be served his noon meal.

On 01/05/21 at 12:42 PM R71 received his meal in a divided plate with large handled utensils. The plate contained a meat stuffed green pepper. R71 stabbed the meal item with a fork, and ate the meat off the fork, getting food on his beard. R71 tried to wipe his beard/face with his right hand by lifting the impaired right hand with his left hand. Observation revealed staff did not offer or assist

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F 677	Continued From page 3	F 677		

R71 with cutting the meat and pepper into bite size pieces.

On 01/05/21 at 02:04 PM, continued observation revealed the resident had remained in the dining room and staff took the resident from the dining room to his room for toileting. The resident had not been offered toileting for over six hours.

On 01/10/21 at 12:43 PM R71 sat in the dining room at the usual restorative table. Staff served him manicotti (large pasta noodle stuffed with cheeses) on a divided plate. R71 was provded regular utensils, not large handled as directed in his plan of care. Observation revealed a long piece of noodle hung from R71's mouth as he ate since staff had not cut the meal item into bite size pieces.

On 01/10/22 at 01:01 PM, Certified Medication Aide (CMA) S stated staff charted the baths in the electronic record. CMA S reported refusals should be recorded in the electronic record also.

On 01/10/22 at 01:55 PM, Administrative Nurse D stated R71 should have been toileted per his plan of care. Administrative Nurse D further stated staff should have cut R71's food into bite size pieces, and provided large handled silverware. Administrative Nurse D said staff should bath the resident per his bathing preferences. Administrative Nurse D verified the lack of documentation R71 had received bathing between 11/17/21 to 01/10/22.

The facility's "Activities of Daily Living" policy, dated 04/27/18, recorded the facility will provide care and services based on the comprehensive assessment of the resident and consistent with

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F 677	Continued From page 4	F 677		

his/her needs or choices for the following activities of daily living: Hygiene, bathing, dressing, grooming, elimination, and toileting. The policy further recorded residents who are not able to carry out activities of daily living and are dependent on staff will receive the necessary services to maintain good nutrition, grooming and personal hygiene.

The facility failed to provide R71 with consistent bathing, toileting, and eating assistance which placed the resident at risk for further decline in ADLs.

- The "Electronic Medical Record" (EMR) for R78 recorded diagnoses of type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), cognitive impairment (when a person has trouble remembering, or making decisions that affect their everyday life), and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

R78's "Quarterly Minimum Data Set" (MDS), dated 12/09/21, documented the resident had moderately impaired cognition, required supervision with one staff assistance for personal hygiene, and dependent upon one staff for bathing.

The "Activities of Daily Living (ADL) Care Area Assessment" (CAA), dated 09/16/21, documented R78 was mostly independent for ADL care, however, he had days when he required supervision or limited assistance to complete a task.

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F 677	Continued From page 5	F 677		

The "ADL Care Plan," dated 12/28/21, documented R78 required assistance of one staff member for nail care and shaving, had diabetes and required a licensed nurse or podiatrist (a person who treats the feet and their ailments) to perform nail care.

On 01/04/21 at 10:56 AM, observation revealed R78 sat in the commons area without shoes and socks. Further observation revealed R78's toenails were longer than the end of his toes, thick, and brown in color.

On 01/05/21 at 09:05 AM, observation revealed R78 with Certified Nurse Aide (CNA) M and R78 stated his shoes were making his big toe hurt. Continued observation revealed CNA M did not take off the resident's shoe to see if there was injury to the resident's toe nor did CNA M tell a nurse the resident complained his toe hurt.

On 01/05/21 at 01:40 PM observation revealed R78's fingernails were longer than the tips of his fingers, jagged, and had brown debris under them.

On 01/05/22 at 01:49 PM, R78 stated he had not had nail care in a very long time and didn't know if his toenails were causing his shoes to be too little and hurt his feet.

On 01/05/22 at 09:30 AM, CNA M verified she had not taken the resident's shoes off to check to see if his big toe was red and verified she did not tell a nurse the resident's toes were hurting.

On 01/05/22 at 01:49 PM, Licensed Nurse (LN) G stated the podiatrist had not been at the facility in a long time and stated all nurses can do the

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F 677	Continued From page 6	F 677		

resident's nail care, they just are busy and do not have time because the resident's toenails are thick and hard to cut.

On 01/06/22 at 09:37 AM, Administrative Nurse D stated the facility had a nurse that provided all the resident's nail care and would look into getting R78's fingernails and toenails cut. Administrative Nurse D further stated the nurse would look at the resident's toes to make sure there was not any injury.

The facility's "Activities of Daily Living" policy, dated 04/27/18, documented the facility would provide the necessary care and services to ensure a resident's abilities in the activities of daily living did not diminish unless circumstances of the individuals clinical condition demonstrated such diminution and was unavoidable. The policy further stated, residents would be given appropriate treatment and services to maintain or improve his/her ability to carry out the activities of daily living and any resident who was unable to carry out activities of daily living and are dependent on staff would receive the necessary care and services to maintain good nutrition, grooming, personal and oral hygiene.

The facility failed to provide nail care for R78, placing him at risk for poor hygiene.