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 _____	02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTH CENTER	440 SE WOODLAND AVENUE 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 The following citations represent the findings of a Health Resurvey and Complaint Investigation #141757, #142803, and #145007. The 2567 was electronically sent to the facility on 02/24/2020.	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: The facility had a census of 101 residents. The sample included 18 residents, with three reviewed for limited range of motion (ROM). Based on observation, record review, and interview, the facility failed to provide restorative services to maintain and/or prevent further decrease in range of motion for sampled Resident (R) 9. Findings Included:	F 688		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/24/2020

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 688	Continued From page 1	F 688		

- R9's "Quarterly Minimum Data Set" (MDS), dated 11/14/19, recorded the resident had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact), inattention, and disorganized thinking. The MDS recorded R9 required extensive staff assistance with transfers, dressing, toileting, personal hygiene, unable to walk, limited ROM on one side of his body, and received no restorative services.

The "Activities of Daily Living (ADL) Care Plan," dated 11/21/19, recorded R9 had left side hemiplegia (paralysis on one side of the body), a history of seizures (sudden disturbance in the brain causes uncontrolled body movements), and a history of falls related to impulsive behaviors and poor safety awareness. The care plan lacked documentation R9 received restorative services to maintain and/or prevent decrease in range of motion.

The 02/03/2020 "MDS Charting Note" recorded R9 a fall risk, wore a safety helmet due to occasional seizures, and continued to transfer himself without asking for staff assistance.

On 02/17/2020 at 08:07 AM, observation revealed R9 wore a safety helmet, propelled his wheelchair with his right foot, and his left foot rested on the wheelchair foot pedal.

On 02/17/2020 at 10:17 AM, Licensed Nurse (LN) G stated the facility did not have a restorative aide, and Certified Nurse Aides (CNAs) and activity staff provided restorative services. LN G stated R9 did not receive restorative services or participate in group exercises.

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F 688	Continued From page 2 On 02/19/2020 at 11:30 AM, Administrative Nurse D stated R9 had limited range of motion, at risk for falls, and should receive restorative services to maintain and/or prevent further decrease in range of motion. The facility's "Restorative Nursing" policy, dated November 2017, directed staff to utilize a restorative nursing program to maintain, or improve a resident's mobility, ADL function, and ROM. The facility failed to provide restorative services to maintain and/or prevent further decrease in range of motion for R9, placing the resident at risk for falls and decreased ADL function.	F 688		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		

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F 812	Continued From page 3	F 812		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 101 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to store and prepare food in accordance with professional standards for food service safety in one of one kitchen. Staff failed to store three different kinds of thawing meat in separate pans in a refrigerator, staff failed to label and date food in three refrigerators and one freezer, and complete refrigerator and freezer temperature logs. Staff failed to discard outdated sanitizer test strips and clean the microwave and a shelf above the grill.

Findings included:

- On 02/16/2020 at 10:33 AM, observation revealed during the initial tour of the kitchen, the following:
Refrigerator #1 had a 15 pound (lb) box of bacon, 11.35 lb box of roasted seasoned turkey thighs, and a 20 lb box of diced beef tips and gravy thawing on the bottom shelf, stacked on top of each other in the same pan.

Refrigerator #2 had an unsealed, undated open plastic bag of sliced tomatoes and sliced cucumbers, and an unlabeled, undated large bowl of cream cheese frosting.

Freezer #5 had an unlabeled, undated plastic bag of French toast sticks and two plastic bags of chocolate chip cookies.

The temperature logs from 02/01/2020 to 02/16/2020 had the following missing documentation:

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Freezer #1 had four missing afternoon temperatures.
Freezer #3 had five missing afternoon temperatures.
Freezer #4 had five missing afternoon temperatures.
Refrigerator #1 had six missing afternoon temperatures.
Refrigerator #2 had two missing afternoon temperatures.
Refrigerator #3 had five missing afternoon refrigerator temperatures.

On 02/18/2020 at 10:17 AM, observation revealed, during follow up to the kitchen the following findings:
The snack refrigerator in a locked room off the kitchen had a 17 ounce (oz) bowl labeled with a resident's name with expiration date 01/09/2020, a four oz jar of strawberry jam with expiration date 11/05/19, and a 16 oz bottle of ranch dressing with expiration date 06/22/19.

Two 50 count sanitizer test strips with expiration date 05/2018, and one with expiration date 01/19.

A microwave with an area of chipped paint, approximately 12 inches (in) by one in, in the front and numerous other sizes of chipped paint inside the microwave. The microwave had numerous sized food particles on inside top and bottom.

A shelf above the grill, approximately two feet by eight in with fuzzy particles all along the edge.

On 02/16/2020 at 10:33 AM, Dietary Aide (DA) BB verified the above findings on initial tour, stated the boxes of bacon, roasted seasoned turkey thighs, and diced beef tips and gravy

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F 812	Continued From page 5	F 812		

should not be left to thaw stacked on top of each other. DA BB stated the sliced tomatoes, sliced cucumbers, bowl of cream cheese frosting, French toast, and plastic bags of chocolate chip cookies should be labeled and dated and discarded them all.

On 02/18/2020 at 10:33 AM, during follow up to the kitchen, Dietary Manager (DM) CC verified the missing refrigerator and freezer documentation, expired foods in the snack refrigerator, fuzzy particles on the shelf above the grill, and microwave chipped paint. DM CC stated staff should check the temperatures of the refrigerators and freezers twice a day and document them and discard food items when expired.

The facility's "Food Storage" policy, dated 08/20/19, documented staff should label all food items. The label must include the name of the food and the date it was opened or prepared, to the date it should be sold, consumed or discarded. Staff should discard food that has passed the expiration date. The policy documented staff should check refrigerator temperatures regularly.

The facility's "Thawing Food" policy, dated 01/13/17, documented all foods will be thawed in the refrigerator at 41 degrees or lower.

The facility failed to store and prepare food in accordance with professional standards for food service safety, placing the 101 residents who received food from the facility kitchen at risk for food borne illness.