STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B006006	A. BUILDING: _____ B. WING _____	C 09/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE MEMORY CARE OF FORT SCOTT	822 S HORTON STREET FORT SCOTT, KS 66701

(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) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of the abbreviated survey for complaint investigation #145650 at the above named facility conducted on 9/19/19 and 9/23/19.	S 000		
S5155 SS=D	26-42-204 (a) Health Care Services (a) The administrator or operator in each home plus shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a) The facility reported a census of 12 residents. The sample included 3 residents. Based on observation, interview and record review the administrator/operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs for 1 of 3 sampled residents (#1) in accordance with the functional capacity screening and the negotiated service agreement in regard to impaired skin integrity, pressure ulcer risk and development of measures to promote healing. Findings included: - Record review on 9/19/19 at 10:45 AM revealed resident #1 moved into the facility on 4/19/18 with	S5155		

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

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S5155	Continued From page 1	S5155		

diagnoses of Alzheimer's, dementia and chronic kidney disease. She had a hospital stay for an obstructed bowel with surgical treatment and returned to the facility on 7/22/19.

The significant change functional capacity screening (FCS) dated 7/22/19 identified the resident with short-term memory deficit and impaired decision making. She was unable to perform the tasks of bathing, dressing, toileting, transferring, eating or medication/treatment management. She needed a wheelchair for mobility.

The negotiated service agreement/health care plan (NSA/HCP) dated 7/22/19 included the resident lacked memory recall, was oriented to self but had difficulty with time or place and needed reorientation through the day with supervision. The resident was unable to perform management of medications or treatments with directions for staff to provide all prescribed medications. The NSA/HCP directed staff to provide total assistance with bathing, hygiene, dressing, toileting, eating and required assistance of 2 staff for transfers between surfaces. Integrity Hospice would provide treatments and colostomy care. The NSA/HCP did not include any information related to the resident's risk for impaired skin integrity due to recent health decline/hospitalization, decreased self-care abilities and decrease mobility. The NSA/HCP failed to be revised with interventions to promote healing and prevent further development of pressure ulcers after one developed on or about 8/19/19.

Review of the resident progress notes between 7/09/19 through 8/30/19 revealed on 7/11/19 a family member took the resident to the

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S5155	Continued From page 2	S5155		

emergency room for repeated emesis with admission to the hospital for possible bowel obstruction.
On 7/22/19 at 4:00 PM - the resident returned from hospital stay for a bowel blockage with a new colostomy and an indwelling urinary catheter. The resident's family chose a hospice provider for services. The note identified a surgical site with staples to the abdomen and no other skin impairment. The notes between 7/28/19 and 8/30/19 (the last note) failed to include any further information about the resident's impaired skin integrity.

Review of the hospice visit notes revealed the resident began services on 7/22/19 with the only noted impaired skin integrity of the surgical site on the abdomen. Visit notes between 7/22/19 and 8/08/19 included ongoing monitoring of the surgical site, bilateral edema of the lower extremities with weeping and wound development on the left calf. The notes included a new area of redness on the mid-back (8/22/19) which developed into a stage 2 (open area - abrasion, blister or shallow crater) pressure ulcer (localized damage to the skin and/or underlying tissue that usually occurs over a bony prominence as a result of long-term pressure or pressure in combination with shear or friction) on 8/26/19. The wound measured 1 cm (centimeter) by 0.5 cm and described the depth as partial thickness.

Observation on 9/19/19 at 10:58 AM with certified staff B and C revealed a gauze wrapped dressing on the resident's left calf, the mid-back directly on the spine had a Mepilex border dressing and the coccyx/sacral (base of the spine/tailbone) area had a Mepilex border dressing in place.

Interview on 9/19/19 at 11:00 AM with certified

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S5155	Continued From page 3 staff C confirmed the resident had impaired skin integrity for a while but she did not know when the areas were discovered. She indicated the wound on the back was an open area. She reported the area on the coccyx/sacral was redness when she last saw it and the Mepilex was placed to protect the area. She was not sure if the area was open or not. Interview on 9/19/19 at 11:16 AM with licensed nurse A confirmed the NSA/HCP lacked any information about any of the resident's impaired skin integrity/wounds or pressure ulcer prevention related to the recent health decline and increased risk factors. She reported hospice staff were the only ones monitoring the wounds and taking care of them. She reported hospice provided a low loss air mattress but could not identify when that intervention was put into place. She reported staff were directed to turn and reposition the resident routinely, position with pillows for comfort and to off-load heels but could not identify when the education to staff occurred and confirmed the NSA/HCP did not include these interventions (air mattress, turning, off-loading). For resident #1, the administrator/operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of the resident in accordance with the functional capacity screening and the negotiated service agreement to address the resident's potential and actual skin impairment, pressure ulcer risk and development of measures to promote healing.	S5155		
S5251 SS=D	26-42-105 (f) (11) Resident Records Documentation of Incidents	S5251		

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S5251	Continued From page 4 (f) (11) documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of the action. This REQUIREMENT is not met as evidenced by: KAR 26-42-204 (a) The facility reported a census of 12 residents. The sample included 3 residents. Based on observation, interview and record review the administrator/operator failed to ensure the 1 of 3 sampled resident's (#1) record included documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions in regard to impaired skin integrity and pressure ulcer development. Findings included: - Record review on 9/19/19 at 10:45 AM revealed resident #1 moved into the facility on 4/19/18 with diagnoses of Alzheimer's, dementia and chronic kidney disease. She had a hospital stay for an obstructed bowel with surgical treatment and returned to the facility on 7/22/19. The significant change functional capacity screening (FCS) dated 7/22/19 identified the resident with short-term memory deficit and impaired decision making. She was unable to perform the tasks of bathing, dressing, toileting, transferring, eating or medication/treatment management. She needed a wheelchair for mobility.	S5251		

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S5251	Continued From page 5 The negotiated service agreement/health care plan (NSA/HCP) dated 7/22/19 included the resident lacked memory recall, was oriented to self but had difficulty with time or place and needed reorientation through the day with supervision. The resident was unable to perform management of medications or treatments with directions for staff to provide all prescribed medications. A hospice provided would provide treatments and colostomy care. The NSA/HCP did not include any information related to the resident's risk for impaired skin integrity due to recent health decline/hospitalization, decreased self-care abilities and decrease mobility. The NSA/HCP directed staff to provide total assistance with bathing, hygiene, dressing, toileting, eating and required assistance of 2 staff for transfers between surfaces. Review of the resident progress notes between 7/09/19 through 8/30/19 revealed on 7/11/19 a family member took the resident to the emergency room for repeated emesis with admission to the hospital for possible bowel obstruction. On 7/22/19 at 4:00 PM - the resident returned from hospital stay for a bowel blockage with a new colostomy and an indwelling urinary catheter. The resident's family chose a hospice provider for services. The note identified a surgical site with staples to the abdomen and no other skin impairment. The next note dated 7/28/19 at 9:30 AM which indicated the resident had crawled out of bed and staff found him/her sitting on the floor without any pain or signs of injury with normal range of motion in all extremities. The nurse assessed the resident with no new redness or bruising of the skin, catheter, colostomy and staples intact. The resident did not remember crawling out of bed	S5251		

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and an intervention placed of a bed alarm. The note included no other information about skin impairment.
The next note dated 8/15/19 at 9:30 AM indicated a wound nurse for hospice visited with recommendation for skin impairment around the colostomy stoma. Another hospice nurse also visited and removed the indwelling urinary catheter. The note included no other information about skin impairment.
The next note dated 8/19/19 at 4:15 PM - hospice nurse gave orders to discontinue scheduled Tramadol at bedtime and continue to have PRN (as needed). The note included no other information about skin impairment.
The next and last note dated 8/30/19 at 4:40 PM - medical care provider visit today with no new orders. The note included no other information about skin impairment.

Review of the hospice visit notes revealed the resident began services on 7/22/19 with the only noted impaired skin integrity of the surgical site on the abdomen. Visit notes between 7/22/19 and 8/08/19 also only identified the surgical site as impaired skin integrity.
On 8/08/19 the note identified a wound on the anterior right lateral mid-thigh. The narrative note indicated this wound was present from hospitalization and related to where the urinary catheter tubing was anchored and the resident picks at the area. The note indicated the wound was without signs and symptoms of infection and the nurse cleaned the area and covered with a dressing. The note included information about the surgical wound and the appearance of the skin at the stoma site.
On 8/15/19 the hospice visit note indicated the right lateral mid-thigh wound was healed and included an assessment of the surgical

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abdominal wound with no other skin impairment was noted.
On 8/19/19 the hospice visit note, narrative section included information about the resident overall status, 3 + edema in bilateral extremities with left calf weeping. The note indicated the resident had a wound on his/her back which was not assessed.
On 8/22/19 the hospice visit note included information about the resident's overall health, ongoing monitoring of the surgical wound, 2 + edema in bilateral extremities which were wrapped in gauze. The note indicated the resident had a red area on the back which the nurse covered with Mepilex border (a self-adherent soft silicone absorbent foam dressing).
On 8/26/19 the hospice visit note included the surgical wound on the abdomen had healed. An area on the mid-back was classified as a stage 2 (open area - abrasion, blister or shallow crater) pressure ulcer (localized damage to the skin and/or underlying tissue that usually occurs over a bony prominence as a result of long-term pressure or pressure in combination with shear or friction. The note included measurements of 1 cm (centimeter) by 0.5 cm and described the depth as partial thickness.
On 8./30/19 hospice visit note indicated wound care to the mid-back stage 2 pressure ulcer was not provided.
The note between 8/30/19 and 9/11/19 were similar documentation about the edema in the lower legs, weeping left calf with treatment in place and the stage 2 pressure ulcer on the mid-back and no other skin impairment noted.

Observation on 9/19/19 at 10:58 AM with certified staff B and C revealed a gauze wrapped dressing on the resident's left calf, the mid-back directly on

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S5251	Continued From page 8 the spine had a Mepilex border dressing and the coccyx/sacral (base of the spine/tailbone) area had a Mepilex border dressing in place. Interview on 9/19/19 at 11:00 AM with certified staff C confirmed the resident had impaired skin integrity for a while but she did not know when the areas were discovered. She indicated the wound on the back was an open area. She reported the area on the coccyx/sacral was redness when she last saw it and the Mepilex was placed to protect the area. she was not sure if the area was open or not. Interview on 9/19/19 at 12:15 PM with licensed nurse A confirmed the resident's record lacked documentation by facility staff of the resident's various impaired skin integrity, actions taken and results of those actions. The administrator/operator failed to ensure the resident record for this resident included documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of the actions in regard to impaired skin integrity and pressure ulcer development.	S5251		
S5335 SS=F	28-39-437 Construction (a) Each home-plus facility shall be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (b) All new construction, renovation, remodeling, and changes in building use in existing buildings shall comply with building and fire codes, ordinances, and regulations enforced by city,	S5335		

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county, and state jurisdictions, including the state fire marshal.
This REQUIREMENT is not met as evidenced by:
KAR 28-39-437 (a)

The memory care facility reported a census of 12 residents. Based on observation, interview and record review the operator failed to protect the health and safety of residents by a failure to keep cleaning chemicals and other chemicals in a locked secured area.

Findings included:

- On 9/19/19 licensed nurse a provided a resident roster of 12 residents and all were marked with impaired cognitive abilities.

During the initial tour on 9/19/19 at 9:21 AM observation revealed resident # 3 ambulated about the hall in a wandering (traveling aimlessly from place to place without purpose) manner and attempted to open a locked exit door. At this time, observation revealed an unlocked electrical/mechanical room on the north hall. The door latch had a locking mechanism which was not engaged. Inside the electrical/mechanical room was a janitorial floor sink with the following chemicals stored on the floor beside it: 1 opened gallon jug of a glass cleaner, an open 3-quart bottle of Pine-Sol all-purpose cleaner (warning label if swallowed drink a glass of water, call a medical provider or poison control) and a 64-ounce jug of liquid carpet cleaner. All 3 items had a warning labels to keep out of reach of children may cause eye and skin irritation.
Also stored in the electrical/mechanical room on the floor by the door was 96-ounce container of Harwood floor cleaner labeled keep out of reach

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S5335	Continued From page 10 of children - if swallowed drink 1-2 glasses of water to dilute and call a medical care provider or poison control. Interview on 9/19/19 at 9:26 AM with certified staff B and C confirmed the electrical/mechanical room should be locked because of the chemicals and the cognitively impaired residents. Certified staff C identified at least 2 resident had wandering behavior and would try the doors. Further observation on 9/19/19 at 9:33 AM revealed the laundry room door on the north hall was also unlocked an opened freely with a turn of the door latch. The door latch had a locking mechanism which was not engaged. In the unlocked laundry were cabinets and counter top. A basket of cleaning chemicals sat on the counter which included the following items labeled to keep out of reach of children: An open/used spray bottle of glass cleaner An open/used spray bottle of spot and stain remover which also included harmful if swallowed, call poison control or medical care provider A spray can of scrubbing bubbles - hazardous to humans A can of Ajax powder cleanser with bleach - maybe harmful if swallowed in large quantities A squeeze bottle of Lysol toilet bowl cleaner - corrosive and harmful if swallowed A spray can of Pledge furniture polish Also, on the counter sat an open with no lid container of All-free liquid laundry detergent pod packs with 2 pod packs in the container. The American Association of Poison Control Centers (AAPCC) warned the concentrated formulation of the laundry pods posed a greater health risk than conventional liquid detergent.	S5335		

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S5335	Continued From page 11 In the upper unlocked cabinet where the time cards were located sat a spray bottle of spray and wash and a spray can of heavy starch In the lower cabinets were 6 different doors and behind each was some kind of cleaning chemical as listed: an unopened container of All-free liquid laundry detergent pod packs, an open container of Oxy-clean, a can of Lysol disinfectant spray, a spray bottle of oxy clean max force, a spray bottle of shout laundry spot and stain remover, a spray can of scrubbing bubbles, a spray can of resolve spot cleaner and a spray bottle of resolve carpet cleaner. All of these items were labeled with various safety warnings and to keep out of reach of children. Interview on 9/19/19 at 9:40 AM with licensed nurse A confirmed the laundry room door should be locked due to the chemicals stored in the room and the facility had wandering cognitively impaired residents. The operator failed to protect the health and safety of residents by a failure to keep cleaning chemicals and other chemicals in a locked secured area.	S5335		