STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B067003	A. BUILDING: _____ B. WING _____	R 06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE MEMORY CARE OF CHANUTE	705 OSA MARTIN BLVD CHANUTE, KS 66720

(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 resurvey for correction order 19-83 and complaint investigation #141958 conducted on 6/11/19 and 6/12/19.	{S 000}		
{S5155} SS=G	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 7 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services which met the needs for 1 of 3 residents (#232) in accordance with the functional capacity screen and the negotiated service agreement. This cognitively impaired, physically dependent resident who had a risk for impaired skin integrity lacked nursing services and routine skin assessments to reduce the risk of pressure ulcer development. The resident developed 2 areas on the right 2nd toe and 1 area on the left 2nd toe.	{S5155}		

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

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{S5155}	Continued From page 1 Findings included: - Record review for resident #232 revealed an admission date of 8/31/17 with diagnoses of dementia, hypertension and hyperlipidemia. The significant change functional capacity screen (FCS) dated 3/21/19 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she was unable to perform tasks of bathing, dressing, toileting, transfer, mobility and identified with total incontinence of bladder. The FCS indicated the resident needed assistive devices of a mechanical lift and a wheelchair. The negotiated service agreement/health service plan (NSA/HSP) dated 3/21/19 directed facility staff to provide total assistance with bathing, toileting and transfers. He/she required total assistance with bowel and bladder due to mobility and needed a total body lift to transfer to the bed for changing of incontinent products. The NSA/HSP lacked any interventions related to the dependent resident's risk for skin alterations/pressure ulcer (pressure injuries of localized damage to the skin and/or underlying tissues as a result of long-term pressure or pressure in combination with shearing). The NSA/HSP was amended on 3/27/19 with the name of an interim director and on 4/15/19 with the name of the new facility director. Page by page record review for nursing routine skin assessments revealed none on the chart. Review of the nursing notes revealed an entry dated 4/26/19 at 12:15 PM (last entry in the record) - resident continues to require 2 staff	{S5155}		

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{S5155}	Continued From page 2	{S5155}		

assistance to transfer with a total body mechanical lift to the wheelchair. He/she cannot propel independently, required total assistance with all activities of daily living and had limited range of motion. He/she had no skin impairments at this time with no edema or swelling... the resident's appetite was good, and weight is stable... will continue to monitor.

Review of the notebook labeled care log book revealed the resident scheduled for a shower on Mondays, Wednesdays and Fridays. The certified staff care log documentation for June 2019 revealed the resident received a bath/shower on Monday 6/03/19, Wednesday 6/05/19 and Friday 6/07/19 with none provided thereafter.

Observation on 6/11/19 at 10:57 AM certified staff A and certified staff B prepared to transfer the resident by total body lift from the bed to the wheelchair. The resident laid in bed dressed in sweat pants and T-shirt with regular socks on his/her feet and no device to keep bed linens off the resident's feet. Certified staff A removed the resident's socks for a further observation. The resident's right foot, 2nd toe had 2 areas of previous open sores which were covered by a scab. The upper area on the 1st joint of the toe measured approximately 0.4 cm (centimeters). The lower scabbed area measured approximately 0.8 cm. The 2nd toe on the left foot in an area between the 2nd toe and 3 toe at the 1st joint had a scabbed area which measured approximately 0.4 cm. Certified staff B reported the areas to licensed nurse C at this time and he/she came to evaluate the areas. He/she was not aware of the areas and had not been told by certified staff of the areas. Certified staff B reported he/she had not cared for the resident recently and was not

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{S5155}	Continued From page 3 aware of the areas. Certified staff A reported caring for the resident on Friday 6/07/19 but did not remember seeing any areas on the resident's toes. Interview with licensed nurse C on 6/11/19 at 1:05 PM revealed he/she only did weekly skin assessments when a resident had an open area or other skin issue. He/she said the certified staff was expected to write any new skin conditions on the certified staff skin sheets and turn in to the nurse for evaluation. He/she reported the certified staff skin sheets were not part of the resident's record and were routinely discarded after a nurse reviewed them. He/she said no certified staff skin sheets had been turned in for the resident in a long time. Licensed nurse C said the resident did not usually wear shoes and he/she was not aware of a cause for the open areas on the toes at this time. The operator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services which met the needs for this resident in accordance with the functional capacity screen and the negotiated service agreement. This cognitively impaired, physically dependent resident who had a risk for impaired skin integrity lacked nursing services and routine skin assessments to reduce the risk of pressure ulcer development. The resident developed 2 areas on the right 2nd toe and 1 area on the left 2nd toe.	{S5155}		
{S5185} SS=D	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home plus shall ensure the provision or coordination of dietary services to residents as identified in each	{S5185}		

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{S5185}	Continued From page 4 resident ' s negotiated service agreement. (b) The supervisory responsibility for dietetic services shall be assigned to one employee. (c) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-42-206 (c) The facility reported a census of 7 residents. The sample included 3 residents. Based on observation, interview and record review the operator failed to ensure staff provided the mechanically altered diet for 1 sampled resident (#261) in accordance with the negotiated service agreement and a medical care provider's order. Findings included: - Record review for resident #261 revealed a readmission from a hospital date of 6/06/19 with diagnosis of dementia, anxiety, edema, muscle weakness, history of cancer, diabetes mellitus type 2 and dysphagia (swallowing difficulty). According to the nursing notes dated 5/31/19 the resident admitted to the hospital after a vomiting episode, signs and symptoms of urinary tract infection and loss of appetite. The significant change functional capacity screen	{S5185}		

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{S5185}	Continued From page 5 (FCS) dated 2/04/19 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she was unable to perform tasks of bathing, dressing, toileting, transfer and mobility. He/she needed physical assistance with eating. The negotiated service agreement/health service plan dated 2/04/19 indicated the facility prepared and served the resident a pureed diet as ordered by his/her physician and he/she required nectar thickened liquids. The resident needed verbal cues to eat slowly, chew food thoroughly or to take a drink. He/she received assistance with opening food packets, cutting up food, and encouraged to completely swallow his/her food before taking a drink. Staff to offer snacks throughout the day. The NSA/HSP had the following amendments: 2/04/19 resident will now receive Levemir insulin which family or nurse will administer 2/04/19 resident will receive accuchecks (blood sugar testing) 4 times a day (fasting and bedtime) 2/11/19 insulin was discontinued 2/11/19 accuchecks 4 times a day discontinued will require accucheck fasting 3/06/19 head of bed to be elevated to 30 degrees at all times. 3/27/19 name of the interim director 4/15/19 name of the new facility director 4/18/19 about his/her pressure ulcer risk and need for repositioning, bowel and bladder management. Review of the medical care provider's orders section of the record revealed a document titled Medication Discharge Report dated 6/06/19. The document lacked a signature of a medical care provider, did not identify the document as a	{S5185}		

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{S5185}	Continued From page 6 medical care provider's written orders and lacked documentation of a diet order for resident #261. The record did not include any orders to resume previous orders for the resident's diet. Interview with licensed nurse D on 6/11/19 at 10:10 AM confirmed the hospital document titled Medication discharge report did not include other orders needed such as diet order. He/she did not get a verbal or phone order from a medical care provider for the resident's readmission. Observation on 6/11/19 at 12:00 PM licensed nurse C prepared and served the resident a pureed diet. The operator failed to ensure staff provided the mechanically altered diet for this resident in accordance with the negotiated service agreement and a medical care provider's order.	{S5185}		
S5300 SS=D	26-42-205 (d) (1-2) Facility Administration of Medications (d) Home administration of resident ' s medications. If a home is responsible for the administration of a resident ' s medications, the administrator or operator shall ensure that all medications and biologicals are administered to that resident in accordance with a medical care provider ' s written order, professional standards of practice, and each manufacturer ' s recommendations. The administrator or operator shall ensure that all of the following are met: (1) Only licensed nurses and medication aides shall administer and manage medications for which the home has responsibility. (2) Medication aides shall not administer	S5300		

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S5300	Continued From page 7 medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205 (d) The facility reported a census of 7 residents. The sample included 3 residents. Based on record review and interview the operator failed to ensure staff administered medications and biologicals for 1 resident (#261) in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #261 revealed a readmission from a hospital date of 6/06/19 with diagnosis of dementia, anxiety, edema, muscle weakness, history of cancer, diabetes mellitus type 2 and dysphagia (swallowing difficulty). According to the nursing notes dated 5/31/19 the resident admitted to the hospital after a vomiting episode, signs and symptoms of urinary tract infection and loss of appetite. The significant change functional capacity screen (FCS) dated 2/04/19 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she was unable to perform tasks of medication/treatment management, bathing, dressing, toileting, transfer/ mobility and needed physical assistance with eating. The negotiated service agreement/health service plan dated 2/04/19 indicated the facility staff	S5300		

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S5300	Continued From page 8	S5300		

would administer the resident's medication as ordered.
The NSA/HSP had the following amendments:
2/04/19 resident will now receive Levemir insulin which family or nurse will administer
2/04/19 resident will receive accuchecks (blood sugar testing) 4 times a day (fasting and bedtime)
2/11/19 insulin was discontinued
2/11/19 accuchecks 4 times a day discontinued will require accucheck fasting
3/06/19 head of bed to be elevated to 30 degrees at all times.
3/27/19 name of the interim director
4/15/19 name of the new facility director
4/18/19 about his/her pressure ulcer risk and need for repositioning, bowel and bladder management.

Review of the medical care provider's orders section of the record revealed a document titled Medication Discharge Report dated 6/06/19. The document lacked a signature of a medical care provider and not identified as a medical care provider orders.

The document titled Medication Discharge Report dated 6/06/19 included a section of new orders which included: amoxicillin 500 mg (milligram) twice a day, amoxicillin/clavulanate 875mg-125 mg twice a day with meals and lactobacillus acidophilus and bulgaricus 3 times a day. The section with medication changes included stop acetaminophen 500 mg 3 times a day PRN for pain or fever and start acetaminophen 500 mg 2 tabs 4 times a day PRN for fever, stop taking metformin 500 mg twice a day and start metformin 500 mg every day. The section for other medications included: anastrozole 1 mg every day, ascorbic acid (vitamin C) 500 mg every day, duloxetine 30 mg every day,

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S5300	Continued From page 9 magnesium hydroxide 30 milliliters every day PRN constipation, memantine 5 mg twice a day, Polymen dressing topically every 3 days to buttocks for skin integrity, montelukast 10 mg daily, multivitamin 1 every day, nystatin topical 100,000 units twice a day for skin, phenazopyridine 1 daily PRN for urinary discomfort, polyethylene glycol 17 gram every other day and daily PRN constipation, rivastigmine 1.5 mg twice a day for dementia, zinc oxide topical twice a day PRN and stop ibuprofen 600 mg every 6 hours PRN pain. Review of the nursing notes revealed an entry dated 5/31/19 at 11:00 AM regarding the resident low-grade temperature, slightly lethargic not eating and notified the resident's durable power of attorney who directed to wait and see what the urinalysis showed to see if he/she would like to have resident taken to the emergency room for fluids. The next entry dated 5/31/19 at 1:00 PM read - cont. (continue) assist with 2 person and wheelchair use with some assist and vital signs ... The next entry dated 6/06/19 at 2:50 PM resident returned to the facility from a named hospital by family transport with orders as follows: APAP/hydro (narcotic pain reliever) 325-5 mg (milligram) one tab by mouth every 6 hours PRN (as needed) for pain, amoxicillin 500 mg 1 tab twice a day with meals for 5 days, amoxicillin/clavulanate 875-125 mg 1 tab twice a day with meals for 5 days, Diflucan 100 mg one tab every other day times 4 doses, probiotic twice a day, change acetaminophen to 500 mg two tabs four times a day, change metformin to 500 mg one tab daily, discontinue ibuprofen and continue current diet. Vital signs ...(listed) ... skin assessment done...	S5300		

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S5300	Continued From page 10 --The medications listed in the nursing note did not match the medications listed in the medication discharge report from the hospital and no evidence of a written order for acetaminophen/hydrocodone 325 mg/5/mg was found in the record. Review of the June 2019 medication administration record revealed licensed nurse D made the changes in medications as indicated on the hospital medication discharge report, wrote in the new orders for the amoxicillin, amoxicillin/clavulanate, metformin 500 mg daily, lactobacillus/acidophilus/bulgaricus twice a day, fluconazole (Diflucan) and acetaminophen/hydrocodone as well as all the other medications listed on the medication discharge report. Interview with licensed nurse D on 6/11/19 at 10:10 AM revealed the nursing note documentation was a report from the hospital for discharge instructions. He/she reported calling the resident's medical care provider on 6/06/19 who was not in the office, so he/she faxed the sheet on provided by the hospital for approval on 6/06/19 and as of 6/11/19 at 10:10 AM he/she had not received a response. He/she did not get a verbal or phone order from a medical care provider for the resident's readmission and to use the medication list from the hospital. The operator failed to ensure staff administered medications and biologicals for this resident in accordance with a medical care provider's written order and professional standards of practice.	S5300		