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 _____	04/18/2019

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 licensure resurvey for the above named facility conducted on 4/17/19 and 4/18/19. Revised 2567 sent to facility on 5/3/2019	S 000		
S 100 SS=E	26-39-103 (a) RESIDENT RIGHTS a) Protection and promotion of resident rights. Each administrator or operator shall ensure the protection and promotion of the rights of each resident as set forth in this regulation. Each resident shall have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the adult care home. This STANDARD is not met as evidenced by: KAR 26-39-103 (a) The facility reported a census of 7 residents. The sample included 3 residents and 1 focused review. Based on observation, interview and record review the operator failed to protect and promote residents' rights to a dignified existence and self-determinations for 2 of 4 residents (#582 and #623). Findings included: - Record review for resident #582 revealed an admission date of 8/29/17 with diagnoses of dementia, atrial fibrillation, hypertension, depression and history of falls. The annual functional capacity screen dated 8/30/18 identify the resident with short-term and long-term memory deficit, impaired memory recall	S 100		

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

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 _____	04/18/2019

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

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S 100	Continued From page 1	S 100		

and decision-making. He/she required physical assistance from staff for all activities of daily living except for eating, was at risk for falls with impaired vision and use a walker.

The negotiated service agreement/healthcare plan dated 8/30/18 identify the resident with impaired cognition which required supervision. The resident had a diagnosis of dementia and needed reminders of place and time throughout the day/ He/she liked to go outside and sit on the patio, took medications for dementia and encouraged to participate in activities or do one-on- one with staff when having exit seeking behavior. The resident appeared to be functional on the surface but upon engaging conversation noted with a lack of memory recall. He/she may not be willing to participate in activities, but staff should encourage as the resident enjoy socialization. He/she had visual impairment but no impairment in communication and facility staff would provide physical assistance with bathing, hygiene, dressing, toileting, transfers and mobility. He/she required assistance from staff with mobility using a walker and a gait belt. He/she had a personal alarm in place for safety and staff to provide frequent visual checks due to poor safety awareness.

Review of the nursing notes revealed an entry on 3/26/19 at 10:15 AM resident continued to ambulate with staff assistance of one, gait belt and a four wheeled walker.

Observation on 4/17/19 at 11:25 AM revealed the resident seated in a regular chair at the dining room table with a personal body alarm in place. Several times prior to the observation the resident had attempted to stand, and a loud sounding alarm sounded each time. At this time, when the

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 _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 100	Continued From page 2	S 100		

resident attempted to get up and the alarm sounded the resident stated "isn't that awful" indicating the noise from the alarm. Licensed nurse B assisted the resident to transfer to the recliner in the living room. At 11:29 AM the resident attempted to stand, the alarm sounded, and certified staff C came from the kitchen area. He/she asked the resident to sit back down stating lunch would be ready in about 15 minutes. At 11:30 AM the resident attempted to stand, the alarm sounded, and certified staff C came from another resident's room called resident #582's name out in a loud frustrated tone to which the resident responded back in a hateful tone "What". Certified staff C then approached the resident seated in a recliner and stood with his/her hands on his/her hips in an authoritative body language and asked the resident to sit for a little longer. Certified staff C told the resident they were trying to get other residents up for lunch and no one was out here to watch him/her. At 11:38 AM certified staff C observed the resident start to attempt to stand and certified staff C who was over by the dining tables called out in a loud voice the residence name with a scolding tone then asked him/her to sit back down and wait for lunch. Several times throughout this observation staff told the cognitively impaired resident lunch would be ready in about 15 minutes. At 11:56 AM the resident asked if it was time yet and certified staff D said yes. The resident started to get up and certified staff D asked him/her to wait a minute while staff D got the resident's walker. When staff D got back to the resident with the walker the resident asked "Now" meaning is it OK to get up. The staff member said to the resident "yes, what do you expect for me to have you just sit here" and the resident responded yes. Once certified staff D assisted the resident to the table he/she asked the resident to lean forward so the

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 _____	04/18/2019

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 100	Continued From page 3	S 100		

gait belt could be removed. The resident did and then said see how fast I behaved.

Interview with licensed nurse be on 4/17/19 at 3:00 PM confirmed staff did not treat this resident with a dignified existence or allow him/her to have self-determination with his/her activities. Nurse B indicate the personal body alarm was a fall risk intervention and indicated the resident had not fallen since 7/22/18 and could be reviewed for whether he/she still needed the intervention.

The operator failed to protect and promote this resident's rights to a dignified existence and self-determinations for this resident.

- Record review for resident #623 revealed an admission date of 8/25/15 with diagnoses of dementia, atrial fibrillation, hypertension, muscle weakness, lower back pain and difficulty walking.

The significant change functional capacity screen dated 7/26/18 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she was not able to perform the activities of daily living of bathing, dressing, toileting, transfers, walking, mobility and he/she needed physical assistance with eating.

The negotiated service agreement/health care plan dated 7/26/18 indicated facility staff would provide total assistance with all activities of daily living.

Observation on 4/17/19 at 9:21 AM revealed licensed nurse B and certified staff D used a total body lift to transfer the resident from the wheelchair to the bed. During the cares including incontinent care certified staff C at 9:25 AM

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 _____	04/18/2019

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

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S 100	Continued From page 4 knocked on the room door but did not wait for a come-in response before opening the door, the opening wider and entering the room. He/she stood inside the room for a minute or so and then exited the room. At 9:27 AM while care still in progress certified staff C again knocked on the door and did not wait to be directed to enter, opened the door, entered the room, waiting a few minutes and exited again. Interview with licensed nurse B on 4/17/19 at 3:00 PM confirmed an expectation for staff to knock and wait to be asked to enter. He/she confirmed staff should not enter rooms during care when there was no reason for them to enter and allow the resident being cared for in dignified manner. The operator failed to protect and promote this resident's rights to a dignified existence.	S 100		
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	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE MEMORY CARE OF CHANUTE	705 OSA MARTIN BLVD CHANUTE, KS 66720

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S5155	Continued From page 5	S5155		

sample included 3 residents and 1 focused review. 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 4 residents (#718) 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 implemented upon return from the hospital with open areas on the buttocks and redness on top of the right 2nd toe with no revision of the health service plan. His/her area on top of the 2nd toe worsened to an open area and he/she developed 2 new open areas on the right uppermost thigh/gluteal fold.

Findings included:

- Record review for resident #718 revealed an admission date of 1/17/15 with diagnoses of dementia, anxiety, edema, muscle weakness and history of cancer. According to the nursing notes the resident on 3/03/19 the resident admitted to the hospital with aspiration pneumonia and urinary tract infection. He/she returned to the facility on 3/06/19.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5155	Continued From page 6	S5155		

plan (NSA/HSP) dated 2/04/19 direct 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 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.

A nursing assessment dated 3/06/19 identified the resident with gaulding on the chest and groin areas, redness on the top of the 2nd toe on the right foot, an open area on the left upper buttocks/sacral area and bilateral lower extremity edema. The nursing assessment had no measurements of the open area or a description of the area to include a more specific location, an approximate size, color or characteristics of the wound.

Review of nursing notes revealed on 3/06/19 at 12:45 PM the resident arrived back at the facility, was given lunch and remained upright for 30 minutes after the meal due to aspiration risk. At 1:50 PM licensed nurse B wrote resident

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 _____	04/18/2019

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

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S5155	Continued From page 7	S5155		

transferred to the bed by total body mechanical lift and assistance of 2 staff. skin assessment completed - listed vital signs - will continue to monitor. The nursing note had no measurements of the open area or a description of the area to include a more specific location, an approximate size, color or characteristics of the wound.

The following represents the notes in session as follows:
Dated 3/08/19 at 1:15 PM by licensed nurse B indicated he/she sent physician orders to the primary care physician to review and sign - awaiting response.
3/12/19 at 9:05 AM received physician orders...
3/26/19 at 11:30 AM - resident continues to require 2 staff assistance and a mechanical lift to transfer to the wheelchair. He/she required total assistance with activities of daily living. Resident has an area on his/her buttocks which licensed nurse B covered with PolyMem dressing today... The note had no measurements of the open area or a description of the area to include a more specific location, an approximate size, color or characteristics of the wound.
3/28/19 at 10:40 AM resident out and returned from primary care physician (PCP) appointment ... new orders to fax blood sugar results, refer resident to wound care for recurring pressure sores, change position every 2 hours to prevent decubitus (pressure sores) ulcers, keep clean and dry, apply PolyMem every 3 days to the pressure wounds until resolved.
3/28/19 at 11:00 AM licensed nurse B wrote called PCP regarding wound care and resident being place on a waiting list with orders to continue treatments as ordered.
3/28/19 at 11:30 AM resident straight catharized for a urinary sample and specimen taken to clinic lab...

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 _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5155	Continued From page 8 4/01/19 at 11:00 AM resident had abnormal urine culture, PCP sent orders for an antibiotic with no other new orders. Note - none of the above nursing notes mention any further nursing assessments of the resident's 2nd right toe redness and no assessment between 3/06/19 and 3/26/19 nor any further assessment after 3/26/19. 4/02/19 at 1:30 PM resident to foot clinic today to trim toenails - cleaned and debrided area to right 2nd toe, apply Silvadene cream and gauze dressing daily until healed. 4/08/19 (next note) at 1:30 PM by licensed nurse B - this nurse assessed area on resident's buttocks. noted the areas are almost healed, will probably leave the current dressings on until they come off or in 3 days (whichever comes first) per order and then contact PCP to discontinue the treatment ... 4/11/19 at 4:00 PM called PCP about areas on buttock healed ... 4/15/19 at 9:15 AM received orders to discontinue wound care... 4/16/19 at 11:00 AM called PCP about medication list and discontinue of some medications not used lately ... 4/17/19 at 7:20 AM received orders to discontinue medication that have not been used ... Note - none of the above nursing notes mentioned any nursing assessments of the pressure ulcer on the resident's toe. The physician orders signed 3/11/19 included treatments as ordered - with the orders of Nystatin to the chronic gaulding, zinc oxide topically twice a day PRN (as needed) - did not specify the location for the application and	S5155		

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 _____	04/18/2019

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

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S5155	Continued From page 9	S5155		

Polymem (a type of dressing to clean wound, balance moisture, reduce inflammation, pain and aid in healing) to buttocks change every 3 days PRN. The orders did not include any interventions for the redness on top of the 2nd toe right foot.

The physician saw the resident at the office and diagnosed the resident with recurrent decubitus ulcer/pressure wounds. He/she ordered to change the resident's position every 2 hours to prevent decubitus ulcers, keep pressure wounds clean and dry, apply PolyMem dressing every 3 days to pressure wound until resolved. The NSA/HSP lacked a revision to include these pressure ulcer prevention interventions and to promote healing.

The podiatrist saw the resident on 4/02/19 and wrote partial thickness wound on right 2nd toe. He/she debrided (to remove all materials that may promote infection or impede healing) loose tissue of the right 2nd toe, cleaned and applied Silvadene cream with a gauze dressing. Orders to continue with wound care daily until healed with no tight shoes.

Review of the March 2019 medication administration record (MAR) revealed the following skin treatments:
wash buttock and peri area with soap and water daily - initialed as completed on day shift and evening shift every day but 1 for March 2019
Zinc oxide 40 % topical ointment apply topical twice a day PRN since 8/22/16 - no initials to indicate treatment provided
PolyMem to buttocks as needed every 3 days per standing orders PRN - with initials on 3/28/19 x 2, 3/29/19 and 3/30/19
Nystatin 100,000u/1gm topical apply to chest and

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 _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S5155	Continued From page 10	S5155		

abdominal folds PRN - with no initials to indicate treatment provided

Review of the April 2019 MAR revealed the following skin treatments:
The same for the Nystatin and Zinc oxide without any initials as being provided
PolyMem to buttocks as needed every 3 days with initials on 4/01, 03, 05, 08, 10, 12 and 15/ 2019
Cover area on the right 2nd toe with Silvadene cream then gauze and tape change daily until healed dated 4/02/19 and initialed as done 4/03/19 thru 4/15/19 when staff wrote order discontinued healed (observation below on 4/17/19 revealed a dressing still in place).

Observation on 4/17/19 at 1:30 PM revealed certified staff C and D used a total body mechanical lift to transfer the resident from the wheelchair to the bed. The resident was incontinent of bowel and urine. Observation of the resident's skin following perineal care revealed multiple areas of redness/recently closed skin in 5 specific places across the upper buttocks/sacral area. On the right uppermost part of the posterior thigh at the gluteal fold was 2 small open circular areas approximately 0.4 centimeters without measurable depth and had surrounding redness. Certified staff C confirmed the areas as new. In the resident's wheelchair was a compressed foam cushion (did not resemble a pressure reducing type cushion) which had an open seam towards the back of the wheelchair and the yellow discolored foam protruded out. The resident's right 2nd toe had a dressing in place and the left 2nd toe rested higher than the other toes and had a small circular area of white excessive dried skin at the first joint. The resident wore non-slid socks and certified staff C reported the resident used to

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 _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S5155	Continued From page 11 wear shoes but not since the area on the toe happened. Interview on 4/17/19 at 3:00 PM with licensed nurse B revealed the above documentation included the only record of the resident's skin breakdown. He/she said the staff give the showers twice a week and report areas of concern but do not make a written record of his/her findings. Licensed nurse B confirmed the NS/HSP did not have pressure ulcer or altered skin integrity interventions to reduce the risk for this cognitively impaired and dependent resident. He/she confirmed the NSA/HSP lacked a revision after the hospital return with altered skin integrity and open wounds. He/she confirmed the record lacked evidence of routine monitoring of the impaired skin integrity (buttocks, toes, chest and groin gaulding). 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 implemented upon return from the hospital with open areas on the buttocks and redness on top of right 2nd toe with no revision of the health service plan. His/her area on top of the 2nd toe worsened to an open area and he/she developed 2 new open areas on the right uppermost thigh/gluteal fold.	S5155		
S5185 SS=E	26-42-206 (a) (b) (c) Dietary Services (a) The administrator or operator of each home	S5185		

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 _____	04/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
S5185	Continued From page 12 plus shall ensure the provision or coordination of dietary services to residents as identified in each 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 and 1 focused review. Based on observation, interview and record review the operator failed to ensure staff provided the mechanically altered diet for 2 of 3 sampled residents (#718 and #623) in accordance with the negotiated service agreement, a medical care provider's order and instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #718 revealed an admission date of 1/17/15 with diagnosis of dementia, anxiety, edema, muscle weakness and history of cancer. According to the nursing notes dated 3/03/19 the resident admitted to the hospital with aspiration pneumonia and urinary	S5185		

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 _____	04/18/2019

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
S5185	Continued From page 13	S5185		

tract infection. He/she returned to the facility on 3/06/19.

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 bathing, dressing, toileting, transfer and mobility. He/she needed physical assistance with eating. The FCS indicated the resident needed assistive devices of a mechanical lift and a wheelchair.

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.

Record review revealed nursing notes dated 3/03/19 at 3:20 PM - certified medication aide (CMA) called licensed nurse B to report the resident had been coughing a lot over the last

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 _____	04/18/2019

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

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S5185	Continued From page 14	S5185		

hour and seemed like he/she could not cough up the phlegm - vital signs were taken with a temperature of 101.3 degrees Fahrenheit, pulse of 111 and oxygen 83% on room air. The note indicated staff administered Tylenol, notified the durable power of attorney (DPOA) who came to see the resident to determine if he/she needed to be taken for evaluation to the emergency room (ER). At 5:45 PM the DPOA decided to take the resident to the ER ... at 7:15 PM resident was admitted to the hospital with diagnosis of aspiration ammonia and urinary tract infection. Nursing notes indicate the resident returned to the facility on 3/06/19 at 12:45 PM. The note indicated the resident had not eaten lunch yet and was given lunch at this time and then remained upright for 30 minutes after the meal due to aspiration risk. The admitting physician orders included a pureed diet with nectar thickened liquids.

Review of the physician's orders signed 3/11/19 included a diet order for pureed food with nectar thick and liquids. The orders lacked any kind of instructions on how to prepare the pureed diet or the liquids.

Record review revealed no documentation from a medical care provider or a licensed dietitian regarding instructions to staff on how to prepare a pureed diet and nectar thickened liquids.

Observation on 4/17/19 at 12:05 PM revealed certified staff C prepared pureed foods for two residents. The menu for the meal was Hamburger with bun, pork-n-beans and green beans. Certified staff C placed two hamburger patties and some gravy into a food processor and processed for about a minute. The end product for the pureed hamburger meat when dished onto

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S5185	Continued From page 15	S5185		

the plate was runny and ran into the other food items. No bread or bun was used in the preparation. Certified staff C then placed two scoops of pork-n-beans with no additional liquid into the processor and processed for a minute. When dished onto the plate it was more solid than the hamburger meat but still somewhat runny. Next, he/she placed 2 4-ounce scoops of green beans with no added liquid and processed. When dished onto the plate the green beans held a shape. Observation indicated certified staff C did not use a recipe or directions while preparing the food items. After dishing the food items certified staff C served the pureed food to the resident.

Observation on 4/17/19 at 12:16 PM revealed certified staff C took a large lidded plastic cup with a straw and already with some clear liquid in it added two of the larger sized scoops of the thickening agent (Thick-it) to the liquid. He/she used the straw and stirred for about 15 seconds then waited several minutes for it to thicken. The clear liquid did not thicken up to a nectar consistency after about 3 minutes so certified staff C stirred it again and said will wait a little longer. After about 4 minutes at approximately 12:20 PM the surveyor asked certified staff C how much water was actually in the container. He/she confirmed not measuring the liquid, but it was a 12-ounce glass so only fill to about 8 ounces. He/she reported adding 2 of the larger scoops of Thick-it. He/she indicated using the directions on the container of Thick-it. Review of the written directions on the container of the thick-it revealed for 4 ounces of water add 3.5 to 4 teaspoons of Thick-it. One tablespoon equals 4 teaspoons equivalent to the larger scoop thus 1 large scoop to 4 ounces of water. Upon request certified staff C measured the liquid in the glass which

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 _____	04/18/2019

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S5185	Continued From page 16	S5185		

measured 12 ounces and therefore needed to have three scoops of thick-it not the two scoops he/she had added. At this time, he/she added another scoop, stirred and within about 30 seconds the liquid was the right consistency.

Interview with licensed nurse B on 4/17/19 at 1:45 PM confirmed staff should prepare the liquids based on the directions on the thick-it container and he/she confirmed the record lacked written directions from a medical care provider or a dietitian on how to prepare either the pureed diet or the nectar thickened liquids.

The operator failed to ensure staff provided the mechanically altered diet and thickened liquids for this resident in accordance with the negotiated service agreement, a medical care provider's order and instructions from a medical care provider or licensed dietitian.

- Record review for resident #623 revealed an admission date of 8/25/15 with diagnoses of dementia, atrial fibrillation, hypertension, muscle weakness, lower back pain and difficulty walking.

The significant change functional capacity screen dated 7/26/18 identified the resident with short-term and long-term memory deficit, impaired memory recall and decision making. He/she was not able to perform the activities of daily living of bathing, dressing, toileting, transfers, walking, mobility and he/she needed physical assistance with eating.

The negotiated service agreement/health service plan dated 7/26/18 indicated the resident needed physical assistance for all facets of eating but at times he/she could self-feed. Staff to prepare his/her meals and is on a pureed diet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE MEMORY CARE OF CHANUTE	705 OSA MARTIN BLVD CHANUTE, KS 66720

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S5185	Continued From page 17 The signed physician orders dated 3/08/19 included pureed diet with no directions on how to prepare the pureed food items. Record review revealed no documentation from a medical care provider or a licensed dietitian regarding instructions to staff on how to prepare a pureed diet and nectar thickened liquids. Observation on 4/17/19 at 12:05 PM revealed certified staff C prepared pureed foods for two residents. The menu for the meal was Hamburger with bun, pork-n-beans and green beans. Certified staff C placed two hamburger patties and some gravy into a food processor and processed for about a minute. The end product for the pureed hamburger meat when dished onto the plate was runny and ran into the other food items. No bread or bun was used in the preparation. Certified staff C then placed two scoops of pork-n-beans with no additional liquid into the processor and processed for a minute. When dished onto the plate it was more solid than the hamburger meat but still somewhat runny. Next, he/she placed 2 4-ounce scoops of green beans with no added liquid and processed. When dished onto the plate the green beans held a shape. Observation indicated certified staff C did not use a recipe or directions while preparing the food items. After dishing the food items certified staff C served the pureed food to the resident. Interview with licensed nurse B on 4/17/19 at 1:45 PM confirmed staff should prepare the liquids based on the directions on the thick-it container and he/she confirmed the record lacked written directions from a medical care provider or a dietitian on how to prepare either the pureed diet	S5185		

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S5185	Continued From page 18 or the nectar thickened liquids. The operator failed to ensure staff provided the mechanically altered diet and thickened liquids for this resident in accordance with the negotiated service agreement, a medical care provider's order and instructions from a medical care provider or licensed dietitian.	S5185		
S5205 SS=J	26-42-104 (a) Disaster and Emergency Preparedness a) The administrator or operator of each home plus shall ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-42-104 (a) The facility reported a census of 7 residents. Operator A identified 5 of the 7 residents required 2 staff assistance to transfer to and from a bed/chair and staffed the facility with 1 staff member from 10:00 PM to 6:00 AM and all 7 residents were cognitively impaired. Based on observation, interview and record review the operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This deficient practice placed the 5 dependent residents in immediate jeopardy for harm, injury or death. Findings included:	S5205		

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S5205	Continued From page 19 - On 4/17/19 at 8:40 AM licensed nurse B reported a facility census of 7 residents and staffing pattern of 2 staff members between 6:00 AM and 10:00 PM with only 1 staff member from 10:00 PM to 6:00 AM. He/she reported part of the night another staff member was available from a sister facility. On 4/17/19 licensed nurse E provided a resident roster which identified 5 of the 7 residents required 2 staff members to assist him/her with transferring between surfaces (bed/chair). All 7 residents were identified as cognitively impaired. Review of the records operator A provided for the evacuation drills conducted on 4/26/18, 9/24/18 and 10/4/18 revealed the facility conducted an evacuation using 4 or more staff to evacuate the residents. The facility routinely staffed only 2-3 staff on the day shift, 2 staff on the evening shift and 1 staff on the overnight shift. Observation on 4/17/19 at 9:21 AM revealed licensed nurse B and certified staff D used a total body mechanical lift to transfer resident #623 from his/her wheelchair to the bed. Review of #623 Negotiated Service Agreement (NSA) dated 7/26/18 for transfers documented "use hoyer lift that requires two staff to transfer." Observation on 4/17/19 at 9:43 AM revealed certified staff C and D used a total body mechanical lift to transfer resident #362 from his/her wheelchair to the bed. Observation on 4/17/19 at 9:55 AM revealed certified staff C and D used a gait belt to assist resident #747 to stand with a front wheeled walker from the toilet to transfer to the	S5205		

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S5205	Continued From page 20 wheelchair. Staff C and D were both needed to provide physical weight bearing assistance on both sides of the resident and with repeated direction/cueing and hand guided movements the resident took a few steps and pivoted to transfer. His/her response to the staff's directions were delayed and his/her movements were slow and spastic. Review of #747 NSA dated 3/2/19 for transfer documented "Staff assistance requires 2 with transfer to wheelchair". Observation on 4/17/19 at 1:30 PM revealed certified staff C and D used a total body mechanical lift to transfer resident #718 from his/her wheelchair to the bed. Interview on 4/17/19 at 2:38 PM with operator A confirmed the staffing pattern for the facility was 1 staff member during 10:00 PM to 6:00 AM and confirmed having 5 of the 7 residents who wear dependent on 2 staff for assistance with transfers. He/she confirmed the facility failed to practice an evacuation with the least amount of staff which would be on duty. The operator failed to ensure the provision of a sufficient number of staff members to take residents who would require assistance in an emergency or disaster to a secure location. This deficient practice placed the 5 dependent residents in immediate jeopardy for harm, injury or death. The jeopardy was removed on 4/17/19 at 3:18 PM when the operator increased staffing on the 10:00 PM to 6:00 AM shift to 2 staff members on duty.	S5205		