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 _____	11/05/2018

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

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named assisted living facility conducted on 10/30,31/2018 and 11/5/2018.	S 000		
S5085 SS=E	26-42-201 (c) Functional Capacity Screen Reassessment (c) Designated staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-42-201(c)(2) The facility reported a census of 11 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the operator failed to ensure designated staff conducted a functional screening to determine 2 (#101 and #103) or 3's functional capacity following a significant change in condition as defined in KAR 26-39-100. Findings included: - Review of resident #101's record revealed he/she admitted to the facility on 6/25/18 with diagnosis of reflux disease, hypertension, pain, depression, constipation and Dementia.	S5085		

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

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S5085	Continued From page 1 Review of the residents functional capacity screen dated 6/25/18 revealed the resident transferred and walked independently. He/she needed staff supervision with bathing, dressing and eating and physical assistance with toileting. The resident also had occasional bladder incontinence and cognitive impairment. Review of the negotiated service agreement dated 6/25/18 revealed staff prepared the resident's water for bathing and provided standby assistance for safety purposes. Staff also provided structured supervision with dressing and physical assistance with toileting. The resident was independent with transfers and mobility. The negotiated service agreement also included the following amendments: 10/11/18 - The resident no longer ambulated except for transfers and could only be 25-50 percent weight bearing. Staff needed to use wheelchair for mobility at this time. 10-24-18 - The resident could not bear weight at this time and is to transfer with assistance of 2 staff using the sit-to-stand lift. He/she is to have on a personal alarm at all times and use the wheelchair for mobility. The record included a change in resident condition form dated 9/28/18 which indicated the resident had a fractured pelvis, needed assistance of 2 staff with transfers using the gait belt and used a wheelchair for mobility. During an interview on 10/31/18 at 9:05 AM certified staff A reported the resident no longer walked and had been using the sit-to-stand lift for transfers for about 2 weeks now. Staff stated prior to using the lift the resident could walk and transfer him/herself without staff assistance.	S5085		

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S5085	Continued From page 2 During an interview on 10/31/18 at 10:25 AM licensed nursing staff B confirmed he/she should have completed a new functional capacity screen to show the change in status. - Review of resident #103's record revealed he/she admitted to the facility on 2/13/18 with diagnoses of neurocognitive disorder with delusions and hypertension. Review of the functional capacity screen dated 2/13/18 revealed the resident was independent with transferring and mobility, required supervision with eating and toileting and physical assistance with bathing and dressing. It also indicated the resident did not use any assistive devices for mobility. The same functional capacity screen had hand written changes dated 8/14/18 which indicated the resident now needed physical assistance with toileting, transfers, and mobility. The resident also used a wheelchair and other assistive device for mobility. Review of the negotiated service agreement included the following amendments: 8/18/18 the resident required assistance of 1-2 staff using a gait belt and walker for transfers and mobility. 8/17/18 - the resident required staff to push him/her in a wheelchair for mobility. The record also included a change in resident condition form dated 7/16/18 indicating the resident could be up with assistance of 2 staff for toileting, transfers, and ambulation. During an interview on 10/31/18 at 1:12 PM	S5085		

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S5085	Continued From page 3 certified staff reported the resident usually required 1 person assistance for walking and transfers now but he/she used to walk independently. During an interview on 10/31/18 at 2:30 PM licensed nursing staff B confirmed he/she should have completed a functional capacity screen when the resident had a significant change in status. The operator failed to ensure designated staff conducted a functional screening to determine 2 of 3 resident's functional capacity following a significant change in condition as defined in KAR 26-39-100.	S5085		
S5171 SS=F	26-42-204 (i) Health Care Services Standards of Practice (i) All health care services shall be provided to residents by qualified staff in accordance with acceptable standards of practice. This REQUIREMENT is not met as evidenced by: KAR 26-42-204(i) The facility reported a census of 11 residents. The sample included 3 residents and 1 focused review. For all residents, the operator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable standards of practice as evidenced by interview and record review for 2 (#101 and #103) of 3 residents. Findings included:	S5171		

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S5171	Continued From page 4 - Review of resident #101's record revealed he/she admitted to the facility on 6/25/18 with diagnosis of reflux disease, hypertension, pain, depression, constipation and Dementia. Review of the residents functional capacity screen dated 6/25/18 revealed the resident transferred and walked independently. He/she needed staff supervision with bathing, dressing and eating and physical assistance with toileting. The resident also had occasional bladder incontinence and cognitive impairment. Review of the negotiated service agreement dated 6/25/18 revealed staff prepared the resident's water for bathing and provided standby assistance for safety purposes. Staff also provided structured supervision with dressing and physical assistance with toileting. The resident was independent with transfers and mobility. The negotiated service agreement also included the following amendments: 10/11/18 - The resident no longer ambulated except for transfers and could only be 25-50 percent weight bearing. Staff needed to use wheelchair for mobility at this time. 10-24-18 - The resident could not bear weight at this time and is to transfer with assistance of 2 staff using the sit-to-stand lift. He/she is to have on a personal alarm at all times and use the wheelchair for mobility. The record included a change in resident condition form dated 9/28/18 which indicated the resident had a fractured pelvis, needed assistance of 2 staff with transfers using the gait belt and used a wheelchair for mobility. Review of the nurses notes dated 9/28/18	S5171		

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S5171	Continued From page 5	S5171		

revealed licensed nursing staff B received a call from a certified staff stating he/she had found the resident on the floor. Licensed nurse advised the staff to check for obvious/visible injuries and noted the resident had a skin tear to his/her right elbow. He/she then advised certified staff to check for range of motion in upper and lower extremities and the resident did not complain of pain with range of motion in upper extremities. When certified staff did range of motion to lower extremities the resident stated it hurt. The nurse then advised certified staff he/she would come and further assess the resident. Upon assessment the resident complained of pain to right side and his/her right leg appeared to be slightly shorter. Resident transported to local emergency room via EMS.

For resident #101, the operator failed to ensure the licensed nurse did not delegate a task that requires the knowledge and judgement of a nurse to unlicensed staff when certified staff were instructed to perform passive range of motion.

- Review of resident #103's record revealed he/she admitted to the facility on 2/13/18 with diagnoses of neurocognitive disorder with delusions and hypertension.

Review of the functional capacity screen dated 2/13/18 revealed the resident was independent with transferring and mobility, required supervision with eating and toileting and physical assistance with bathing and dressing. It also indicated the resident did not use any assistive devices for mobility.

The same functional capacity screen had hand written changes dated 8/14/18 which indicated the resident now needed physical assistance with

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toileting, transfers, and mobility. The resident also used a wheelchair and other assistive device for mobility.

Review of the negotiated service agreement included the following amendments:
8/18/18 the resident required assistance of 1-2 staff using a gait belt and walker for transfers and mobility.
8/17/18 - the resident required staff to push him/her in a wheelchair for mobility.

The record also included a change in resident condition form dated 7/16/18 indicating the resident could be up with assistance of 2 staff for toileting, transfers, and ambulation.

Review of the nursing notes revealed the following:
7/29/18 at 10:10 PM licensed nursing staff B received a call from certified staff they observed the resident on the floor. Licensed nursing staff advised certified staff to check resident for any injuries. Certified staff reported to licensed nursing staff B the resident had a red mark on his/her back.
9/12/18 at 12:30 AM licensed nursing staff B received a call from a certified staff stating the resident had gotten up out of bed and fell. The resident had split open his/her right ear from the night stand. Instructed the certified staff to check range of motion in upper and lower extremities and certified staff noted it was intact. Licensed nurse then advised staff to send the resident to hospital emergency room for evaluation.

For resident #103 the operator failed to ensure the licensed nurse did not delegate a task that required the knowledge and judgement of a nurse to unlicensed staff when certified staff were

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S5171	Continued From page 7 instructed to perform passive range of motion. During an interview on 10:47 AM certified staff AC reported when a resident fell staff called licensed nursing staff B and he/she walked staff through assessing range of motion. Staff stated he/she moved the residents arms and legs and checked their hips for pain. Staff C stated during this he/she actively moved the residents arms and legs. During an interview on 10/31/18 at 10:48 AM certified staff A reported if a resident fell he/she checked for any bleeding or obvious injuries. If the resident did not have any obvious injuries staff would sit the resident up and take them where they want to go. The staff call licensed nurse B and will have the resident move their arms and legs. If the resident cannot understand then the staff move their arms and legs for them to make sure they do not have any injuries. During an interview on 10/31/18 at 11:00 AM certified staff D reported of a resident fell staff called licensed nursing staff B and he/she then directs staff on what to do. Staff try to get the resident to move their arms and legs on their own but if they don't understand we move them for them. If the resident has any pain then we stop. During an interview on 10/31/18 at 10:25 AM licensed nursing staff B reported he/she trained staff when a resident fell, staff needed to check range of motion. Staff move the resident's arms and legs up and down, in and out and if there is any pain they stop. For all residents, the operator failed to ensure all health care services were provided to residents by qualified staff in accordance with acceptable	S5171		

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S5171	Continued From page 8 standards of practice when the licensed nurse delegated passive range of motion, a task that requires the knowledge and judgement of a nurse to unlicensed staff.	S5171		
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 medication through the parenteral route. This REQUIREMENT is not met as evidenced by: KAR 26-42-205(d) The facility reported a census of 11 residents. The sample included 3 residents and 1 focused review. Based on interview and record review the operator failed to ensure staff administered medications and biologicals in accordance with medical care provider's written order and professional standards of practice for 1 (#101) of 3 residents.	S5300		

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S5300	Continued From page 9 Findings included: - Review of resident #101's record revealed he/she admitted to the facility on 6/25/18 with diagnosis of reflux disease, hypertension, pain, depression, constipation and Dementia. Review of the residents functional capacity screen dated 6/25/18 revealed the resident could not manage his/her own medications and medical treatments. Review of the negotiated service agreement dated 6/25/18 revealed staff managed and administered the resident's medications and medical treatments. Review of the physicians orders revealed the following: 9/28/18 - Lortab 5/325 mg 1 tablet every 6 hours as needed for pain. (maximum of 4 tablets per day) 10/12/18 Lortab 5/325 1 tablet every 8 hours. Max daily amount - 3 tablets. Review of the October 2018 medication administration record included a row for administration that said: Hydro/Apap (Lortab) 5/325 mg. give 1 tablet every 6 hours as needed for pain. The medication administration record had not been revised to include the change in the Lortab order. The medication administration record revealed on 10/13/18 the resident received Lortab at 9:00 AM and again at 3:00 PM. On 10/31/18 the resident received it at 12:30 AM and again at 7:00 AM. Both times the resident received the medication less than 8 hours apart. During an interview on 10/31/18 at 9:50 AM	S5300		

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S5300	Continued From page 10 certified staff C reviewed the medication administration record and confirmed according to what the record said the resident could have the Lortab every 6 hours, which was up to 4 times a day. During an interview on 10/31/18 at 10:25 AM licensed nursing staff B reported he/she had missed the change in the order for the Lortab. The operator failed to ensure staff administered medications and biologicals in accordance with medical care provider's written order and professional standards of practice.	S5300		