STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089043	A. BUILDING: _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDLAND CARE RESIDENTIAL CENTER	120 SW FRAZIER CIRCLE TOPEKA, KS 66606

(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 are the result of a survey for re-licensure conducted on 8/21/18 and 8/22/18 at the above named in Topeka, KS.	S 000		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility 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 26-41-204(a) The facility reported a census of 15 residents. The sample included 3 residents. Based on record review, observation and interview for 2 (#821, 823) sampled residents requiring health care services, the operator failed to 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. Findings included: - Record review for resident #821 recorded admission date of 4/1/18 with diagnoses of: coronary artery disease, dementia, depression,	S3155		

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
	N089043	A. BUILDING: _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDLAND CARE RESIDENTIAL CENTER	120 SW FRAZIER CIRCLE TOPEKA, KS 66606

(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
S3155	Continued From page 1	S3155		

glaucoma, hypotension, hypothyroidism and osteoarthritis.

Functional Capacity Screen (FCS) dated 7/26/18 recorded resident unable to perform bathing, dressing and management of medications and treatments. Resident required assistance with toileting, transfer and walk/mobility. Resident has a history of falls, unsteadiness, impaired vision, impaired hearing, impaired decision making and inappropriate behavior. Resident has problems with long term memory, short term memory, memory recall and decision making.

Negotiated service agreement and Health care service plan (NSA/HCSP) dated 7/26/18 recorded resident to receive assistance with bathing, dressing, management of medications, toileting, transfers, walk/mobility and has impaired hearing.

Observation on several occasions on 8/21/18 and 8/22/18 revealed resident in community area holding a stuffed dog with a cast on his/her right arm.

Observation on 8/22/18 at 9:35am, in resident's room revealed a twin bed with 2- quarter rails in raised position.

Nurse's notes dated 7/19/18 at 3:00pm recorded resident fall out of bed (resulting in a fracture of the right wrist).

Interview on 8/21/18 at 4:50pm with licensed nurse #B stated resident has a body alarm in use when in bed to prevent falls.

HCSP lacked interventions for falls, vision, hearing, impaired cognition, impaired decision making and inappropriate behavior, use of bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089043	A. BUILDING: _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDLAND CARE RESIDENTIAL CENTER	120 SW FRAZIER CIRCLE TOPEKA, KS 66606

(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
S3155	Continued From page 2 rails and use of a personal alarm while in bed as a fall intervention. Interview on 8/22/18 at 12:00pm with licensed nurse #B stated resident is not able to use the side rails and they are not to be in raised position. He/she confirmed rails cannot be removed and HCSP lacked intervention to prevent staff raising of the side rails. He/she confirmed resident is given the stuffed dog to calm the resident and HCSP lacked interventions for impaired cognition including use of the stuffed dog as a behavior intervention. Record review for resident #823 recorded admission date of 12/18/17 with diagnoses of diabetes mellitus type 2, dementia, and bipolar disorder. FCS dated 3/13/18 recorded resident required assistance with bathing, management of medications and unable to perform management of treatments. Resident has problems with cognition including long term memory, short term memory, memory recall and decision making. Resident has a history or inappropriate behavior. NSA/HCSP dated 3/13/18 recorded resident to be assisted with bathing and management of medications and treatments. Observation on 8/22/18 at 9:35am in resident's room revealed a twin bed with one quarter side rail in raised position. Interview on 8/22/18 at 12:00pm with licensed nurse #B stated when resident gets agitated he/she just wants to go to bed. He/she stated side rail is used to hold resident's bed remote and wants it in the raised position. He/she confirmed	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N089043	A. BUILDING: _____ B. WING _____	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDLAND CARE RESIDENTIAL CENTER	120 SW FRAZIER CIRCLE TOPEKA, KS 66606

(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
S3155	Continued From page 3 facility does not conduct side rail assessments. HCSP lacked interventions for use of a side rail to maintain access to his/her bed remote and interventions for impaired decision making and inappropriate behaviors. For residents #821 and 823 residents requiring health care services, the operator failed to 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	S3155		