STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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 8/1/18 and 8/2/18.	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 7 residents. The sample included 3 residents. Based on observation, interview and record review the 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 (#401) in accordance with the functional capacity screening and the negotiated service agreement in regard to the use of bed rails. Findings included: - Record review for resident #401 revealed an admission date of 5/27/14. He/she had diagnoses of dementia, tachycardia, gastric esophageal reflux disease and skin cancer.	S5155		

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
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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 1 The significant change functional capacity screen (FCS) dated 7/10/18 indicated the resident was unable to perform and needed total assist with bathing, dressing, toileting, transfers, walk/mobility and eating. The negotiated service agreement (NSA) dated 7/10/18 indicated the facility would provide the resident with assistance for all activities of daily living (ADLs) and he/she received Hospice care. The NSA lacked information about the use of bed rails. Review of the health service plan (HSP) dated 7/10/18 revealed facility staff would provide total assistance with all ADLs and he/she received Hospice care for terminal illness. The HSP lacked information about the use of bed rails. The record lacked an assessment to verify the rail was not a restraint, the resident used the rail safely and the rail design/attachment/gaps and mechanisms were safe. Observation on 8/1/18 at 1:53 PM revealed the resident rested in bed with bilateral quarter bed rails in the upright position. Interview on 8/1/18 at 1:53 PM with direct care staff A revealed the resident received the bed from Hospice care a couple weeks ago and he/she was able to use the rails to hold on to during care. The resident was not able to use the rails since the weekend (7/28/18 and 7/29/18). Interview on 8/1/18 at 2:45 PM licensed nurse B confirmed the resident had bed rails attached to the bed frame and no assessment to safety of the bed rail was completed.	S5155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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 2 The operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services to meet the needs of this resident in accordance with the functional capacity screening and the negotiated service agreement in regard to the use of bed rails.	S5155		
S5251 SS=E	26-42-105 (f) (11) Resident Records Documentation of Incidents (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 26-42-105 (f)(11) 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 each resident's record included documentation of all incidents, symptoms and other indication of illness or injury including the date, time of occurrence, action taken and results of the action for 2 of 3 sampled residents (#401 and #402). Findings included: - Record review for resident #401 revealed an admission date of 5/27/14. He/she had diagnoses of dementia, tachycardia, gastric esophageal reflux disease and skin cancer.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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
S5251	Continued From page 3 The significant change functional capacity screen (FCS) dated 7/10/18 when compared to the annual FCS dated 1/3/18 revealed the resident went from needing physical assist with activities of daily living (ADLs) to unable to perform any part of the ADLs (bathing, dressing, toileting, transfers, walk/mobility and eating). The negotiated service agreement dated 7/10/18 indicated the facility would provide the resident with assistance for all ADLs and he/she received Hospice care. Review of the health service plan (HSP) dated 7/10/18 and compared to the 4/19/18 HSP revealed the resident went from moderate assistance with ADLs to fully dependent for ADLs. He/she received Hospice care for terminal illness. Review of the resident progress notes between 1/19/17 through 6/14/18 (the last entry made) revealed no entries related to the resident's decline in ADL function or starting on Hospice care services. Observation on 8/1/18 at 1:53 PM revealed direct care staff A provided total care for incontinence, repositioning and oral care. The resident was unable to assist with any of his/her cares. Interview on 8/1/18 at 1:53 PM with direct care staff A revealed the resident began to have a health decline about a month ago and went on Hospice care. He/she reported as of the weekend (7/28/18 and 7/29/18) the resident was not really eating or drinking and today 8/1/18 he/she just let fluid run back out of his/her mouth when fluids were provided.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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
S5251	Continued From page 4	S5251		

Interview on 8/1/18 at 2:45 PM licensed nurse B confirmed the resident had a health status change, began Hospice care services and declined further over the past few days. He/she confirmed the record lacked information about the resident's health status change and current status.

The operator failed to ensure each resident's record included documentation of all incidents, symptoms and other indication of illness or injury including the date, time of occurrence, action taken and results of the action for this resident with a overall decline and need for Hospice care regarding terminal illness.

- Record review for resident #402 revealed an admission date of 11/13/17 with diagnoses of dementia, hypertension, osteoporosis, coronary artery disease and hypothyroidism.

The annual functional capacity screen dated 5/3/18 indicated the resident needed physical assistance with bathing, dressing, toileting, transfers, walk/mobility and eating.

The negotiated service agreement (NSA) dated 5/3/18 identified the facility staff should provide the resident with assistance for bathing, dressing, toileting/incontinence, transfer and mobility. An addendum to the NSA dated 6/25/18 indicated the resident required increased assistance since hospitalization. He/she could transfer safely with assist of 1 care giver, may need feeding assistance but at time just needed cueing.

Review of the health service plan dated 5/3/18 revealed the resident required some assistance with bathing, moderate assistance with dressing, total assistance with personal hygiene/oral care,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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
S5251	Continued From page 5 moderate assistance for toileting, some assistance with mobility and supervision with transfers and eating. Review of the resident progress notes between 5/10/18 and 7/12/18 revealed the following: 6/15/18 at 12:00 PM the resident had increased difficulty walking, does not seem to be tracking instructions as well as previous. He/she was eating and drinking ok with no fever or illness present. Pleasant when spoken to but just unable to track instructions. (no further documentation regarding monitoring of the resident's condition, actions taken, or results of actions taken) The next entry was dated 6/19/18 at 8:30 AM ambulation remains poor but no symptoms of any other issues at this time. The next entry was dated 6/25/18 at 4:00 PM resident home from hospital, medication changes noted, diet restrictions noted and teaching of staff completed. Interview on 8/1/18 at 1:09 PM with licensed nurse B confirmed the record lacked evidence of monitoring the symptoms identified on 6/15/18 action taken and results of the action. He/she confirmed the record lacked information regarding events leading up to and including identification of admission to the hospital for treatment of a health status change. The operator failed to ensure each resident's record included documentation of all incidents, symptoms and other indication of illness or injury including the date, time of occurrence, action taken and results of the action for this resident with a health status change which resulted in hospitalization.	S5251		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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
S5258	Continued From page 6	S5258		
S5258 SS=E	26-42-102 (d) Staff Qualifications Employee Records (d) The employee records and agency staff records shall contain the following information: (1) Evidence of licensure, registration, certification, or a certificate of successful completion of a training course for each employee performing a function that requires specialized education or training; (2) supporting documentation for criminal background checks of facility staff and contract staff, excluding any staff licensed or registered by a state agency, pursuant to K.S.A. 39-970 and amendments thereto; (3) supporting documentation from the Kansas nurse aide registry that the individual does not have a finding of having abused, neglected, or exploited a resident in an adult carehome; and (4) supporting documentation that the individual does not have a finding of having abused, neglected, or exploited any resident in an adult care home, from the nurse aide registry in each state in which the individual has been known to work as a certified nurse aide. This REQUIREMENT is not met as evidenced by: KAR 26-42-102(d)(3) The facility census totaled 7 residents. Based on interview and record review the operator failed to have evidence the registry was checked prior to working for 4 of 6 newly hired direct care providers (certified nurse aide E or certified medication aides C, D and F). Findings included:	S5258		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B059006	A. BUILDING: _____ B. WING _____	08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF MCPHERSON	1411 DOVER ROAD MCPHERSON, KS 67460

(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
S5258	Continued From page 7 - The facility provided a list of 13 employees hired since last resurvey review. Review of the personnel records on 8/1/18 revealed the records lacked evidence of the facility checking with the registry before the following staff began working: certified nursing assistance (CNA) E with a hire date of 4/25/17 had the registry verification dated 6/22/17, certified medication aide (CMA) C with a hire date of 6/01/17 had registry verification dated 6/22/17, CMA D with a hire date of 3/22/17 had registry verification dated 6/22/17. Further record review on 8/1/18 at 4:00 PM revealed CMA F with a hire date of 7/23/18 had an undated registry verification. During an interview on 8/1/18 at 10:30 AM with licensed nurse B confirmed the personnel records for CNA E, CMA C and D lacked evidence of checking the registry prior to the date he/she began working. On 8/1/18 at 4:00 PM licensed nurse B confirmed the registry verification in CMA F's employee file lacked a date to indicate the registry was checked prior to working. The operator failed to have evidence the registry was checked prior to working for 4 newly hired direct care providers.	S5258		