STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	07/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

(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 findings represent the findings of the licensure resurvey for the above named facility conducted on 7/17/18 and 7/18/18.	S 000		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility 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 26-41-201 (c)(2) The facility reported a census of 14 residents. The sample included 3 residents. Based on observation, interview and record review the administrator failed to ensure designated staff conducted a functional capacity screening following a significant change in condition for 2 of 3 sampled residents (#801 and #802). Findings included: - Record review for resident #801 revealed an admission date of 2/9/15. He/she had the following diagnoses: hypertension depression, anxiety and weakness.	S3081		

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

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S3081	Continued From page 1	S3081		

The annual functional capacity screen (FCS) dated 2/9/18 indicated the resident needed physical assistance with dressing/bathing, independent with toileting, transfers and walking/mobility. The record lacked any other FCS.

The negotiated service agreement (NSA)/health care plan (HCP) dated 2/9/18 directed nursing staff to provide physical assistance to the resident with dressing/undressing, bathing and toileting. The NSA included the resident used half-rails for repositioning.

An amended NSA dated 6/4/18 directed staff to provide physical assistance with toileting to make sure the resident is safe, required a 1 person assist with all transfers, 1 person assist with all mobility due to weakness.

Observation on 7/17/18 at 1:44 PM revealed direct care staff D propelled the resident in a wheelchair from the TV/activity area to his/her room. Direct care staff D applied a gait belt, assisted the resident to stand with a walker and walk into the bathroom.

Interview on 7/17/18 at 1:44 PM with direct care staff D revealed the resident needed more assistance since she returned from the hospital in May 2018.

Interview on 7/17/18 at 2:17 PM with licensed nurse C confirmed the resident had a significant change in his/her functional abilities and licensed nurse C failed to complete a significant change FCS after the resident's change in abilities.

The administrator failed to ensure designated staff conducted a functional capacity screening

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S3081	Continued From page 2 following a significant change in condition for this resident. - Record review for resident #802 revealed an admission date of 7/18/17. He/she had the following diagnoses: osteoarthritis, hypertension, dementia, depression, hypothyroidism and insomnia. The admission functional capacity screen (FCS) dated 7/18/17 indicated the resident needed supervision with bathing but was otherwise independent with activities of daily living. The record lacked any other FCS. The negotiated service agreement (NSA)/health care plan (HCP) dated 7/18/17 directed staff to provide physical assistance with bathing of getting in/out of the shower. Staff should provide physical assistance as needed with transfers depending on the chair which the resident used. The resident was independent with dressing, toileting and personal hygiene. An amended NSA dated 12/6/17 indicated areas of change were bowel/bladder management, dressing/undressing, ambulation and transfers. The NSA indicated staff would assist the resident with dressing due to the resident inability to bend at the waist related to hip fracture precautions. Staff would assist the resident to/from the bathroom and with incontinence products as needed. staff would assist the resident with all ambulation using a walker, gait belt and stand by assist. On 2/8/18 the resident completed physical therapy and could ambulate independently with the walker. An amended NSA dated 5/15/18 indicated the resident had changes in functional abilities of	S3081		

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S3081	Continued From page 3	S3081		

bathing/showering, bowel/bladder management, dressing/undressing, ambulation, personal hygiene and eating. The resident required physical assistance in/out of the shower and showering. The resident had increased incontinence of bowel and bladder and required staff to take him/her to the bathroom every 2 hours and assist with incontinent products. The resident needed physical assistance with dressing/undressing, personal hygiene, at times with eating, when weak he/she needed physical assistance to transfer and 1 person assist with ambulation due to him/her being unsafe ambulating independently.

Review of the resident progress notes revealed on 4/16/18 the resident returned to the facility from a hospital stay for pneumonia. On 4/29/18 at 1:25 PM the resident had a change of status from breakfast of walking then had to be lifted and taken by wheelchair back to room. resident's pulse was weak, he/she would not respond verbally but later did respond when staff changed his/her clothing. Family notified. On 4/30/18 at 12:00 PM staff went to get resident for lunch and the resident appeared weak, was alert and able to communicate he/she just could not walk temperature 99.5, blood pressure 128/65, pulse 105, respirations 20 with oxygen saturation of 97%. Licensed nurse C notified the physician. On 5/1/18 8:00 AM the physician ordered lab testing. On 5/2/18 the physician indicated the lab tests were ok except for low potassium and prescribed potassium chloride 10 milliequivalents daily. On 5/9/18 at 8:00 AM staff notified licensed nurse C the resident had an open area on his/her buttocks. On 5/14/18 at 9:40 AM staff alerted licensed nurse C the resident was not feeling well, shaky and confused. The nurse obtained vital signs and notified the physician. On 5/21/18

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S3081	Continued From page 4 at 1:30 PM staff received a fax back from the physician regarding the resident not swallowing his/her medications. On 5/23/18 at 3:00 PM physician extender E saw the resident with concerns of overall decline and not eating. On 5/24/18 at 1:30 PM staff received a fax from the resident's physician regarding health status with orders to discontinue all medications except Tylenol, milk of magnesia, artificial tears and Desitin. Staff to assist the family with setting up Hospice care/comfort care. Interview on 7/17/18 at 3:51 PM licensed nurse C confirmed the resident had a significant change in functional abilities since admission and he/she did not completed a significant change FCS. The administrator failed to ensure designated staff conducted a functional capacity screening following a significant change in condition for this resident.	S3081		
S3155 SS=D	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:	S3155		

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S3155	Continued From page 5 KAR 26-41-204(a) The facility reported a census of 14 residents. The sample included 3 residents. Based on observation, record review and interview the administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of each resident and were in accordance with the functional capacity screening and negotiated service agreement for 1 of 3 sampled residents (#801) regarding bed rail use and safety. Findings included: - Record review for resident #801 revealed an admission date of 2/9/15. He/she had the following diagnoses: hypertension depression, anxiety and weakness. The annual functional capacity screen (FCS) dated 2/9/18 indicated the resident needed physical assistance with dressing/bathing. The negotiated service agreement (NSA)/health care plan (HCP) dated 2/9/18 directed nursing staff to provide physical assistance to the resident with dressing/undressing, bathing and toileting. The NSA included the resident used half-rails for repositioning. An amended NSA dated 6/4/18 directed staff to provide physical assistance with toileting to make sure the resident is safe, required a 1 person assist with all transfers, 1 person assist with all mobility due to weakness. The facility resident roster provided on 7/17/18 indicated the resident had half-rails attached to	S3155		

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the bed.

The record lacked an assessment to verify the half-rails were not a restraint, the resident used the half-rail safely and the half-rail design/attachment/gaps and mechanisms were safe.

Review of the resident progress notes between 5/25/17 and 7/14/18 revealed no entries about the resident use of half-rails on the bed, purpose or safety of half-rail use.

Observation on 7/17/18 at 1:44 PM revealed direct care staff D propelled the resident in a wheelchair from the TV/activity area to his/her room. Direct care staff D applied a gait belt, assisted the resident to stand with a walker and walk into the bathroom. The resident's bed had a half-rail attached on both sides of the bed with 1 side in the upright position.

Interview on 7/17/18 at 1:44 PM with direct care staff D revealed the resident needed assistance to get in and out of the bed but could reposition him/herself in the bed. Direct care staff D reported the resident used the half-rails to turn side to side.

Interview on 7/17/18 at 1:50 PM with certified medication aide A revealed both half-rails were placed by staff in the upright position when the resident was in the bed. The half-rails allowed the resident to turn side to side independently.

Interview on 7/17/18 at 2:17 PM with licensed nurse C revealed he/she did not know if the record contained an assessment of the resident's side rail for usage and safety. He/she had not completed one and indicated the use of bed rails

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S3155	Continued From page 7 was addressed in the NSA. On 7/17/18 at 5:12 PM licensed nurse C confirmed the facility lacked a policy regarding bed rail use. The administrator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services which met the needs of this resident and were in accordance with the functional capacity screening and negotiated service agreement regarding the use of bed rails.	S3155		
S3200 SS=E	26-41-205 (d) (1-2) Facility Administration of Medications (d) Facility administration of resident ' s medications. If a facility 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 facility has responsibility. (2) Medication aides shall not administer medication through the parenteral route. This REQUIREMENT is not met as evidenced by:	S3200		

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S3200	Continued From page 8 KAR 26-41-205 (d) The facility reported a census of 14 residents. The sample included 3 residents. Based on record review and interview the administrator failed to ensure that all medications and biologicals were administered to 3 of 3 sampled residents (#801, #802 and #803) in accordance with a medical care provider's written order and professional standards of practice. Findings included: - Record review for resident #801 revealed an admission date of 2/9/15. He/she had the following diagnoses: hypertension depression, anxiety and weakness. The annual functional capacity screen (FCS) dated 2/9/18 indicated the resident was unable to self-administer medications and treatments. The negotiated service agreement (NSA)/health care plan (HCP) dated 2/9/18 directed nursing staff to administer the resident's medications. Review of the most recent recapitulation of the physician orders signed on 7/3/18, noted by licensed nurse C and compared to July 2018 medication administration record (MAR) revealed the following discrepancies in following the physician orders: The July 2018 MAR included Tylenol 500 mg 1 tab every 6 hours as needed (PRN) and Tylenol 500 mg 2 tabs every 6 hours PRN. The physician's order did not include these orders. The physician's ordered Gaviscon regular strength 30 milliliters (ml) 4 times a day (QID) after meals (PC) and hours of sleep (HS), PRN. Review of the July 2018 MAR revealed a	S3200		

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transcription to Mag-AL Plus 30 ml every 6 hours PRN for indigestion. Review of the active ingredients in Gaviscon revealed it contained aluminum hydroxide 254 milligrams (mg) in 5 ml and magnesium carbonate 237.5 mg in 5 ml. Review of the ingredients for Mag-Al Plus revealed it compared to Maalox and antacid/antigas medication with aluminum hydroxide 1200 mg, magnesium hydroxide 1200 mg and simethicone 120 mg in each 30 ml dose. This medication included simethicone which Gaviscon does not and Gaviscon had more milligrams of aluminum hydroxide (1,524 mg) and magnesium (1,425 mg).

Interview on 7/17/18 at 3:417 PM with licensed nurse C confirmed the physician visit with orders dated 7/3/18 had a different Tylenol/acetaminophen order than the facility's current medication administration record. He/she did not know Gaviscon and Mag-Al Plus were not the same. He/she confirmed noting the document to indicate he/she had reviewed the document, but he/she did not compare the medication orders with what the facility had on file.

The administrator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order and professional standards of practice.

- Record review for resident #802 revealed an admission date of 7/18/17. He/she had the following diagnoses: osteoarthritis, hypertension, dementia, depression, hypothyroidism and insomnia.

The admission functional capacity screen (FCS) dated 7/18/17 indicated the resident was unable

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S3200	Continued From page 10 to self-administer medications and treatments. The negotiated service agreement (NSA)/health care plan (HCP) dated 7/18/17 directed nursing staff to administer the resident's medications. Review of the most recent recapitulation of the physician orders signed on 6/20/18, initialed by licensed nurse C and compared to July 2018 medication administration record (MAR) revealed the following discrepancies in following the physician orders: The July 2018 medication administration record (MAR) Tylenol ES (extra strength) 650 milligrams (mg) - ES means 500 mg - 1 tablet by mouth every 4 hours as needed (PRN) for pain. The physician's order included acetaminophen 325 mg 2 tabs (650 mg) by mouth every 6 hours PRN. The July 2018 included Ativan 0.5 mg 1 or 2 tablets by mouth or sublingual every 4 hours PRN for terminal anxiety, restlessness or agitation with directions to notify the nurse. The MAR indicated the resident received the medication 4 times between July 1 and 17th administered by certified medication aides (CMA) A, F and G. Review of the notes section revealed no indication the nurse was consulted to make the assessment and directions for amount to administer. Review of the resident's progress notes also revealed no entries about the resident's symptoms or consulting with the nurse. The MAR indicated on 7/7/18 at 1:30 PM CMA A administered 2 tablets. Interview on 7/17/18 at 3:417 PM with licensed nurse C confirmed the physician visit with orders dated 6/20/18 had a different Tylenol/acetaminophen order than the facility's current medication administration record. He/she confirmed initialing the document to indicate	S3200		

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S3200	Continued From page 11 he/she had reviewed the document, but he/she did not compare the medication orders with what the facility had on file. He/she confirmed the documentation lacked any evidence the nurse was consulted to assess the resident's condition and give the CMAs directions on the dosage to administer. The administrator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order and professional standards of practice. - Record review for resident #803 revealed an admission date of 12/20/17. He/she had diagnoses of rhabdomyolysis, hypertension, stage 3 kidney disease, pulmonal infiltrate and right knee pain. The admission functional capacity screen dated 12/20/17 indicated the resident was unable to self-administer his/her medications. The negotiated service agreement (NSA)/health care plan (HCP) dated 12/20/17 directed staff to administer the resident's medications per the medication administration record (MAR). Review of the most recent recapitulation of the physician orders signed on 6/20/18, initialed by licensed nurse C and compared to July 2018 medication administration record (MAR) revealed the following discrepancies in following the physician orders: The physician orders included Claritin 10 milligrams (mg) by mouth daily and Zantac 300 mg by mouth daily at bedtime. Neither of these 2 orders was on the July 2018 MAR. The July 2018 MAR included dry eye relief 2	S3200		

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S3200	Continued From page 12 drops to affected eye every 2 hours as needed (PRN) and the physician's orders did not include this medication. The July 2018 MAR included 2 separate entries for Colace (Colace 100 mg daily and Colace 100 mg twice a day PRN). The physician's orders were for Colace 100 mg by mouth daily PRN. Interview on 7/17/18 at 3:417 PM with licensed nurse C confirmed the physician visit with orders dated 6/20/18 included Claritin and Zantac which were not on the July 2018 MAR, the July 2018 MAR included dry relief medication which was not on the physician orders and the Colace orders did not match the physician's orders. He/she confirmed initialing the document to indicate he/she had reviewed the document, but he/she did not compare the medication orders with what the facility had on file. The administrator failed to ensure that all medications and biologicals were administered to this resident in accordance with a medical care provider's written order and professional standards of practice.	S3200		
S3261 SS=E	26-41-105 (f) (11) Resident Record 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:	S3261		

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S3261	Continued From page 13 KAR 26-41-105 (f)(11) The facility reported a census of 14 residents. The sample included 3 residents. Based on observation, record review and interview the administrator failed to ensure 1 of 3 resident's records (#803) included 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 in regard to an open area and skin condition on the resident's bottom. Findings included: - Record review for resident #803 revealed an admission date of 12/20/17. He/she had diagnoses of rhabdomyolysis, hypertension, stage 3 kidney disease, pulmonal infiltrate and right knee pain. The admission functional capacity screen dated 12/20/17 indicated the resident needed physical assistance with bathing, dressing, toileting, transfers, walking and mobility. The negotiated service agreement (NSA)/health care plan (HCP) dated 12/20/17 directed staff to provide physical assistance with bathing, hygiene, dressing, toileting, transfers, walking and mobility. The NSA did not include any information related to risk for skin integrity breakdown. The resident roster provided on 7/17/18 indicated the resident had a skin condition. Upon interview with licensed nurse C he/she reported the resident had some open areas on his/her buttocks. Review of the resident's progress notes revealed	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N005007	A. BUILDING: _____ B. WING _____	07/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PLACE SENIOR LIVING OF HOISINGTON	259 WEST 6TH STREET HOISINGTON, KS 67544

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S3261	Continued From page 14 on 1/18/18 at 9:00 AM staff reported to licensed nurse C the resident had some breakdown on his/her bottom. The nurse assessed and initiated the standing order of wash with saline and apply triple antibiotic ointment (TAO). The nurse indicated staff would use a barrier cream in between treatments. Later that day, the physician responded with orders to wash with saline, cover with TAO and a Mepilex dressing (a thin foam dressing) every other day. Review of the resident's progress notes between 1/18/18 and 4/13/18 revealed no other assessments of the residents open areas on his/her bottom. On 4/13/18 at 11:00 AM licensed nurse C recorded the pharmacy did not have the barrier cream the resident normally used and nurse C obtained an order to use Calmoseptine twice a day (BID) PRN for a rash on the buttocks. This entry did not indicate if the resident had any open areas. Review of the resident's progress notes between 4/13/18 and 7/12/18 revealed no other entries about the resident's skin condition. Review of the July 2018 medication administration record (MAR) revealed an order on 7/2/18 to clean sore on buttocks with wound wash, apply TAO, Mepilex and Tegaderm every 3 days. with initials of certified medication aide (CMA) A as being administered on 7/17/18. Observation on 7/17/18 at 3:33 PM with licensed nurse C revealed the resident did not have a dressing in place. His/her buttocks did not have open area but had dry skin on the gluteal edges with what appeared as small fissures/cracks in the skin. To the right of the gluteal crease was an area about 1 inch an oblong shaped of discolored	S3261		

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S3261	Continued From page 15 skin resembling healed tissue from previous injury. Interview with licensed nurse C on 7/17/18 at 3:30 PM revealed he/she had not seen the resident's skin in a while and was not sure of the status of the open area. He/she confirmed the record lacked documentation related to the skin condition with monitoring for the outcome of the actions taken starting 1/18/18 and 7/2/18. The administrator failed to ensure this resident's record included 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 in regard to an open area and skin condition on the resident's bottom.	S3261		