STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	B073001	A. BUILDING: _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING OF LARNED HOME PLUS	710 W 9TH STREET LARNED, KS 67550

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S 000	INITIAL COMMENTS The following citations represent the findings of the resurvey at the above named facility on 4/25/18 and 4/26/18.	S 000		
S5155 SS=E	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 10 residents. The sample included 3 residents. Based on observation, interview and record review for 3 of 3 residents sampled (#601, #602, and #603) 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 the negotiated service agreement regarding fall prevention. Findings included: - Record review for resident #601 revealed an admission date of 8/27/15 with diagnosis of Alzheimer's disease.	S5155		

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

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S5155	Continued From page 1 The significant change functional capacity screen dated 8/16/17 indicated the resident required physical assistance with transfers, walking and mobility. The negotiated service agreement (NSA)/health service plan (HSP) dated 8/16/17 indicated the resident needed full physical assistance from staff for transfers, physical assistance with mobility by wheelchair and total assistance with toileting. The NSA included a sheet titled Fall Intervention Plan dated 8/27/15 which included a listing of 37 different interventions a licensed nurse could use to prevent further falls. The sheet included the following additions: 4/13/17 - item #7 (monitor closely post fall period) - without a specified time frame of post fall period this is not a long-term intervention for fall prevention. 7/10/17 - item #7 continue to monitor 8/7/17 - movement standby 8/12/17 - #21 maintain pathway free of obstruction No date - item #1 (visual checks at specified time intervals) 1 on 1 monitoring post fall (without a specified time frame) No date - item #7 No date - item #7 No date - item #7 No date - item #7 Scoop Mattress 3/29/18 Review of the resident progress notes revealed the following entries: 4/13/17 at 8:15 PM resident was walking (did not included location) and appeared to trip over feet falling against door frame and sliding to floor. No injuries noted and was found lying on right side. The note lacked any intervention to prevent	S5155		

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S5155	Continued From page 2 further falls or evidence of close monitoring with the next note dated 4/18/17. 7/10/17 at 2:00 PM staff reported a non-injury fall (no location), vital signs within normal limits. Resident denied any complaints of injury or pain, no level of consciousness change (LOC). Staff assisted resident back to the chair and he/she continued to deny concerns. The note lacked any intervention to prevent further falls or evidence of close monitoring with the next note dated 7/12/17. 8/6/17 at 6:00 PM resident was in living room, attempted to get up from the chair and lost his/her balance falling to the floor. No LOC or injury and denied pain with full range of motion (ROM) to all extremities. Assisted up and monitored throughout the shift. Review of the facility fall investigation indicated the resident was getting up from the couch. Actions taken to reduce resident's risk included monitor closely and stand by assist upon rising. 8/12/17 at 2:30 PM received a call that resident had fallen and was found in hallway. Denies LOC and no injuries noted with full ROM to all extremities, denies pain or concerns and vital signs within normal limits (WNL). Assisted to feet and placed in chair. Review of the facility's incident report/fall investigation dated 8/12/17 with fall time of 2:20 PM revealed staff were giving shift report and heard a loud noise in the hallway. Staff fount the resident on the floor in the hallway. The resident had been wandering in the hallway prior to the fall. The investigation indicated no actions were taken to prevent future falls with previous intervention of stand by assist in place. There were no identified obstructions or clutter in the hallway.	S5155		

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S5155	Continued From page 3 8/13/17 at 4:58 PM received call that staff had found the resident on the floor by a chair in the dining room with no injuries, LOC, vital signs WNL and denied pain. Full ROM to all extremities will continue to monitor - standby assist with rising. Review of the facility incident report/fall investigation dated 8/13/17 with a incident time of 4:45 PM revealed the resident was in the dining room, stood from his/her dining room chair and fell. Neither had a new intervention to prevent future falls. 8/19/17 (no time) received call that resident was found on the floor. Tag alarm still in place (no previous indication of a personal alarm placement). Denied LOC, pain or injury with full ROM all extremities. Resident assisted back to wheelchair. One on one monitoring post fall (without a specified timeframe), no new orders and continue to monitor. The notes lacked evidence of monitoring with the next note dated 9/11/17. Review of the incident report (no fall investigation available) dated 8/19/17 with incident time of 2:25 PM which include the same information with a location of small living area. The string was too long on the tag alarm which staff adjusted (no indicator of how staff would know the length needed for future fall prevention). No resident progress notes for a fall on 11/13/17. The Fall incident report/investigation dated 11/13/17 indicated the resident fell at 12:15 AM when certified staff responding to the sound of the bed alarm going off and found the resident on the floor next to his/her bed laying on his/her stomach. The nurse was notified, no injuries denied pain. The only action listed was to monitor closely post fall. The notes lacked evidence of monitoring with the next note dated 11/16/17.	S5155		

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S5155	Continued From page 4 11/16/17 at 12:14 AM which included the information as listed above from the incident report/fall investigation. The next note after that was dated 12/6/17. 12/6/17 at 8:00 AM resident found on floor on 12/5/17 at 10:45 PM apparently slid out of bed. He/she had a quarter inch skin tear on the right eye brow and some mild bruising with no other apparent injuries. Next entry 1/4/18. Review of the incident report/Fall investigation indicated staff heard the alarm and found the resident sitting on the floor right next to the bed. The action taken included tag alarm on - string was shortened to alert staff when he/she first attempted to get up. This intervention was the same as 8/19/17 fall and again does not give a reference point on the length of the cord for staff to ensure proper placement of the alerting device. 1/4/18 at 9:00 AM included on 1/3/18 at 11:00 PM the resident rolled out of his/her bed on to the floor with no injuries noted. Review of the incident report/fall investigation indicated staff moved the bed against one side of the wall, used a rolled blanket to remind resident of the edge of the bed. This intervention is not reflected in the NSA/HSP so that all staff knew the intervention to prevent further falls from the bed. 3/29/18 at 2:15 AM resident rolled out of bed lying face down on the floor. He/she had a carpet burn on his/her forehead and chin with no other injuries. Review of the incident report/ (no fall investigation available) revealed staff had went back to do a reposition and change when found the resident face first on the floor. The tag alarm was on but did not sound. The incident report did not include when staff had last seen the resident, positioned the resident or whether a rolled	S5155		

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S5155	Continued From page 5	S5155		

blanket was in use or why the tag alarm did not sound. The NSA/HSP was updated to include a scoop mattress (a mattress with elevated edges of about 3-4 inches to define the edges) after the resident had fallen from the bed 4 times.

Observation on 4/25/18 at 3:03 PM revealed the resident's bed had a scoop mattress.

Interview on 4/25/18 at 3:37 PM with administrator D confirmed not all the falls as listed had incident reports and/or fall investigations. He/she confirmed some of the investigations did not identify the causal factor of the fall and/or a new intervention to prevent future falls. He/she confirmed the NSA/HSP did not include all the falls with a intervention specific to the causal factors of the fall.

The facility's policy titled Fall Management dated 2014 directed staff to complete a fall risk assessment if the FCS indicated or the resident had fallen. If a fall occurs update the Fall Intervention Plan accordingly.

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 the negotiated service agreement regarding fall prevention.

- Record review for resident #602 revealed an admission date of 1/24/13 with diagnosis of dementia.

The annual functional capacity screen dated 8/22/17 indicated the resident required total assistance by 2 staff for transfers and was unable

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S5155	Continued From page 6 to walk. The negotiated Service Agreement/Health Care Plan dated 8/22/17 directed staff to provide total assistance with all activities of daily living with 2 staff needed for transfers. The NSA included a sheet titled Fall Intervention Plan with a start date of 8/25/15 which included a listing of 37 different interventions a licensed nurse could use to prevent further falls. The sheet included the following additions: 8/25/15 annual #18 continue body pillow, #1 visual checks at specified time intervals and #12 lower bed position. No date - #7 monitor closely post fall period (without identification of how long the fall period was) Review of the fall risk assessment dated 8/25/15 revealed a score of 12 with 10 or more indicating a high risk for falls. Review of the resident progress notes between 12/4/17 and 4/16/18 revealed on 2/25/18 at 4:00 AM staff reported to the nurse the resident rolled out of bed with no injuries or expression of pain. Slight red area on forehead, vital signs within normal limits and denied concerns. Assisted back to bed. The note lacked any indication of the cause for the fall or intervention to prevent future falls. Review of the facility's incident report/fall investigation dated 2/25/18 at 4:00 AM revealed the resident was sleeping in bed prior to the fall with no time of last seen by staff or care provided. Staff heard a loud bang and went to find where it came from. Staff observed the resident on the floor beside his/her bed. The resident had rolled	S5155		

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S5155	Continued From page 7 out of bed (did not indicate how this happened for this totally dependent resident) and had a bump on his/her forehead. Staff were instructed to monitor and pad bed to prevent rolling out. The investigation also indicated the bed was not at the proper bed height. Observation on 4/25/18 at 1:11 PM revealed certified medication aide (CMA) A and certified nursing assistant (CNA) B used a gait belt to transfer the resident from the wheelchair to the bed. The resident could stand, took a few minimal movement steps and was pivoted towards the bed by staff assistance. He/she made non-sensical vocalizations which increased in volume and tone during the transfer but quieted once in bed. Staff positioned him/her on the left side facing the wall the bed was against. Staff placed a couple pillows under his/her shoulders and head with 1 pillow to his/her back. The bed was at a standard bed height. Interview on 4/25/18 at 1:13 PM with CMA A revealed the resident is not really a fall risk because he/she does not move. The resident preferred to lay on his/her left side and other than drawing up his/her knees he/she would stay in the same position until staff returned to care for him/her. Interview on 4/25/18 at 1:14 PM with CNA B revealed the same information. He/she heard about the resident falling out of bed but did not know any of the details. He/she reported the resident is dependent on staff to be repositioned every 2 hours when in bed. Interview on 4/25/18 at 3:37 PM with administrator D confirmed the incident report/fall investigation and progress notes did not include	S5155		

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causal factors of how/why the resident fell out of the bed. The investigation lacked information to whether the previous interventions of body pillow and visual checks were in place. He/she confirmed the NSA/HSP did not include a fall prevention related to the fall from bed on 2/25/18 for this dependent resident.

The facility's policy titled Fall Management dated 2014 directed staff to complete a fall risk assessment if the FCS indicated or the resident had fallen. If a fall occurs update the Fall Intervention Plan accordingly.

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 the negotiated service agreement regarding fall prevention.

- Record review for resident #603 revealed an admission date of 5/5/17 with diagnoses of osteoarthritis, peripheral vascular disease, hypertension, non-insulin dependent diabetes mellitus and dementia.

The admission functional capacity screen dated 5/5/17 indicated he/she needed supervision with transfers/walking and physical assistance with toileting and bathing.

The negotiated service agreement (NSA)/health service plan (HSP) dated 5/5/17 indicated the resident needed supervision with transfers/mobility with cueing and oversight or encouragement to ambulate safely. He/she needed physical assistance from staff for toileting. The NSA included a sheet titled Fall

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S5155	Continued From page 9 Intervention Plan dated 5/5/17 which included a listing of 37 different interventions a licensed nurse could use to prevent further falls. The sheet included the following additions: No date - #9 (provide rest areas in areas of ambulation) No date - #7 (monitor closely post fall period) - without a specified time frame of post fall period this is not a long-term intervention for fall prevention. No date - #1 (visual checks at specified time intervals) - time fram not specified No date - #7 No date - #7 and 30-minute visual checks The fall risk assessment dated 5/5/17 scored 11 with 10 or more being a high fall risk. Subsequent assessments when a fall occurred dated 11/5/17 score of 11, no assessment for 11/19/17 fall, 12/20/17 and 2/1/18 remained an 11. Review of the resident progress note revealed the following entries: 11/5/17 at 8:50 AM non-injury fall reported. No change in level of consciousness (LOC), vital signs within normal limits (WNL) and denied pain/concerns. He/she had full range of motion (ROM). Monitor closely. The notes lacked any evidence of monitoring closely with the next note dated 11/7/17 about a medication change. Review of the incident report/fall investigation revealed staff heard a loud bang from the resident's room went to his/her room and observed the resident sitting on his/her bottom next to the bed. The narrative indicated the resident slid off the bed. The nurse advised staff to check on the resident frequently post fall (no guidance of a time frame or duration). The resident often miss uses the walker and would turn it sideways or backwards. The investigation	S5155		

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indicated the resident already had an alarm in place but the investigation did not indicate if the alarm sounded, was functioning properly and when staff had last seen the resident. The NSA/HSP did not include the use of an alarm.

11/19/17 at 12:40 PM the resident tried to sit down in a chair and there was no chair behind him/her. No injury, denied pain or concerns, stable condition, vital signs WNL and no LOC. He/she had full ROM to all extremities. The nurse advised staff to monitor the resident closely. The notes lacked any evidence of monitoring the resident with the next note dated 12/2/17. Review of the incident report/fall investigation revealed no other information.

12/20/17 at 8:00 PM resident appeared to trip with walker over the coffee table, fell backward hitting back of his/her head. Small red area in middle of head. The notes lacked no intervention or evidence of a neurological evaluation after striking his/her head. The next note was dated 2/1/18. Review of the incident report/fall investigation revealed the resident was walking with his/her walker in the living room by the TV. He/she appeared to trip with walker on coffee table. The investigation include possible need to relocate coffee table to allow more room for walkers. No evidence the coffee table was relocated at that time.

2/1/18 at 11:50 AM resident heard falling out of bed - was trying to use bathroom and no injuries noted. No interventions listed or review of causal factors. Review of the incident report/fall investigation revealed staff heard a noise, went to resident's room and found him/her on the floor between the bed and the closet. The resident was incontinent and appeared to by trying to go to the

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restroom. His/her last known activity was sleeping. The investigation did not identify when staff last assisted the resident to the bathroom and or visualized him/her. The actions taken included visual checks every 30 minutes.

A request to review evidence of the 30-minute checks was made to Licensed nurse C resulted in no documentation.

Observation on 4/25/18 at 12:15 PM - 1:00 PM revealed the resident stood up from the dining room chair and attempted to ambulate with no walker in use. Staff were present in the area and redirected the resident to sit down with the offer of desert. The redirection took several attempts. At 1:15 PM he/she laid on the couch in the living room with his/her eyes closed and remained there the rest of the afternoon.

Interview on 4/25/18 at 1:18 PM with certified medication aide A revealed the resident was a fall risk and the staff made frequent visual checks on the resident and attempted to redirect and assist him/her. He/she was assisted to the bathroom every 2hours and as needed.

Interview on 4/25/18 at 3:37 PM with administrator D confirmed the undated additions to the NSA/HSP could not be linked to the resident falls and did not include interventions specific to the causal factors as identified in the investigation if there was an investigation.

The facility's policy titled Fall Management dated 2014 directed staff to complete a fall risk assessment if the FCS indicated or the resident had fallen. If a fall occurs update the Fall Intervention Plan accordingly.

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S5155	Continued From page 12 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 the negotiated service agreement regarding fall prevention.	S5155		