STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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 a resurvey conducted at the above named facility on 2-26-18, 3-1-18, 3-5-18, 3-6-18, and 3-7-18	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by:	S3028		

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
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3028	Continued From page 1 KAR 26-41-101(f)(3)(A)(B)(C)(D)(E)(F) The facility identified a census of 19 residents. The sample included 3 residents. Based on record review, interview, and observation for 1 (#100) of 3 residents sampled, the operator failed to ensure each potential allegation of abuse or neglect was reported to the department within 24 hours, and investigated. Findings included: - Record review for resident #100 revealed an admit date of 11-11-16 with diagnoses of dementia, degenerative joint disease, insulin dependent diabetic, hypertension, gout, and chronic obstructive pulmonary disease. The admission functional capacity screen (FCS) dated 11-2-16 and annual FCS dated 11-2-17 recorded resident independent with toileting, transfer, walking/mobility, experienced short-term memory loss, memory recall, decision making, falls/unsteadiness, and impaired vision. FCS comments: History of falls, frequent falls and family aware of problems forgetting walker and falls from chair. The admission negotiated service agreement (NSA) dated 11-2-16 recorded resident required medication set up and independent with bathing dressing, ambulation, and toileting. Annual NSA dated 11-11-17 recorded resident now required assistance with bathing, dressing, and toileting. The admission health care service plan (HCSP) dated 11-11-16 recorded resident independent with bathing, dressing, grooming, toileting, cognition: short-term memory loss, memory recall, impaired decision making, has impaired	S3028		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3028	Continued From page 2	S3028		

vision and wears glasses. For mobility resident has a walker and does not use regularly. The annual HCSP dated 11-11-17 recorded resident now requires assist with bathing.

The nurses notes recorded the following:

2-8-17 at 8:30 a.m. notified by staff of fall in front of recliner in living room. Resident incontinent of feces. Resident stated could not remember what happened. Resident has an abrasion on left forearm.

4-26-17 (no time) Notified by staff of fall in front of recliner. Resident forgot to lower the foot rest. No injuries noted. Reminded resident to use walker. Remind certified staff to remind resident to use walker at all times. Resident has history of falls.

12-5-17 at 11:30 p.m. Notified by staff of fall out of bed, found resident sitting on left side of bed in front of small night stand. Resident 'unsure of what happened but hit my face.' Small amount of bleeding from nose. Swelling noted to left eye/nose. Family notified and took resident to hospital due to swelling. Resident ambulated to wheelchair.

12-18-17 at 9:30 a.m. Notified by staff of fall in courtyard outside. Resident followed other residents outside and checked the weather after morning meal. Resident was in sitting position with hematoma on forehead. Advised certified staff to transport to emergency room for evaluation due to pain in wrist and hematoma to forehead. Resident returned to facility with splint to right wrist and return for further evaluation. Operator visited with family about resident not being outside unattended and aware of frequent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3028	Continued From page 3 falls and possibility of need for higher level of care. Facility provided incident reports for each fall. The incident reports lacked documentation of an investigation to determine factors that may have contributed to the fall to rule out possible abuse or neglect. On 2-26-18 at 11:50 a.m. observed certified staff E dial insulin pen for resident #100 to self-inject. Resident self-injected own insulin and was in cheerful mood. Resident got up from seat on walker and pushed the walker backwards out of restroom and then turned around and walked to dining room using his/her walker without difficulty. Interview on 3-1-18 at 2:30 p.m. with licensed nurse I stated the HCSP did not have interventions for falls/unsteadiness, resident was non-compliant with use of walker, confirmed resident experienced impaired cognition and the incidents were not reported to the department. For resident #100 the operator failed to ensure each potential allegation of abuse or neglect was reported to the department within 24 hours and investigated.	S3028		
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.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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 4	S3155		

This REQUIREMENT is not met as evidenced by:
KAR 26-41-204(a)

The facility identified a census of 19 residents. The sample included 3 residents. Based on record reviews, interview, and observations for 2 (#100 and #200) of 3 residents sampled, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary health care services (HCS) that meet the needs of each resident and are in accordance with the functional capacity screen (FCS) and the negotiated service agreement (NSA).

Findings included:

- Record review for resident #100 revealed an admit date of 11-11-16 with diagnoses of dementia, degenerative joint disease, insulin dependent diabetic, hypertension, gout, and chronic obstructive pulmonary disease.

The FCS dated 11-2-16 and the FCS dated 11-2-17 recorded resident independent with toileting, transfer, walking/mobility, experienced short-term memory loss, memory recall, decision making, falls/unsteadiness, and impaired vision. FCS comments: History of falls, frequent falls and family aware of problems forgetting walker and falls from chair.

The NSA dated 11-2-16 recorded resident independent with bathing dressing, ambulation, and toileting. The NSA dated 11-11-17 recorded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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 5	S3155		

now required assistance with bathing, dressing, and toileting.

The HCSP dated 11-11-16 and 11-11-17 included 'for mobility resident has a walker. The HCSP lacked additional interventions to address falls.

The nurses notes recorded the following:

2-8-17 at 8:30 a.m. notified by staff of fall in front of recliner in living room. Resident incontinent of feces. Resident stated could not remember what happened. Resident has an abrasion on left forearm. No other injuries noted.

4-26-17 (no time) Notified by staff of fall in front of recliner. Resident forgot to lower the foot rest. No injuries noted. Reminded resident to use walker. Remind certified staff to remind resident to use walker at all times. Resident has history of falls.

12-5-17 at 11:30 p.m. Notified by staff of fall out of bed, found resident sitting on left side of bed in front of small night stand. Resident unsure of what happened but hit my face. Small amount of bleeding from nose. Swelling noted to left eye/nose. Family notified and took resident to hospital due to swelling. Resident ambulated to wheelchair. No other injuries noted.

12-18-17 at 9:30 a.m. Notified by staff of fall in courtyard outside. Resident followed other residents outside and checked the weather after morning meal. Resident was in sitting position with hematoma on forehead. Advised certified staff to transport to emergency room for evaluation due to pain in wrist and hematoma to forehead. Resident returned to facility with splint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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 6	S3155		

to right wrist and return for further evaluation. Operator visited with family about resident not being outside unattended and aware of frequent falls and possibility of need for higher level of care.

On 2-26-18 at 11:50 a.m. observed certified staff E dial insulin pen for resident #100 to self-administer. Resident self-administered own insulin and was in cheerful mood. Resident got up from chair on walker and pushed the walker backwards out of restroom and then turned around and walked to dining room using the walker without difficulty.

Interview on 3-1-18 at 2:30 p.m. with licensed nurse I stated the HCSP did not have interventions for falls/unsteadiness, the resident was non-compliant with use of walker and confirmed resident experienced impaired cognition.

For resident #100, the operator failed ensure licensed nurse provided or coordinated necessary HCS for fall when resident identified at risk for fall.

- Record review for resident #200 revealed an admit date of 3-14-14 with diagnoses of dementia, coronary artery disease, hypertension, depression and muscle weakness.

The FCS dated 3-14-16 recorded resident independent with toileting, transfer, walking/mobility, eating, continence, communication, required physical assistance with bathing and dressing, no problems with cognition, and experienced falls/unsteadiness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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 7 The NSA dated 3-14-16 recorded resident required services for bathing, dressing/grooming, and medication set up and administration. The HCSP dated 3-14-16 recorded resident independent with grooming, eating, ambulation, bladder continence, cognition intact, staff will assist with bathing, dressing. On 11-19-16 physical therapy for strengthening. 8-21-16 pacemaker insertion, assist as needed. The record lacked updated HCSP. 8-5-16 Discharge instructions for permanent pacemaker and Implantable Cardioverter Defibrillator (ICD). Do not raise elbow on the operative side above shoulder for six weeks. Do not lift greater than 5 to 7 pounds with arm on operative side for six weeks. Watch for bleeding, if bleeding starts lie down and hold pressure and get immediate medical attention. Someone needs to look at wound every day. Inspect for signs or symptoms of infection. Wear immobilizer for forty-eight hours and then at night for four weeks. The HCSP lacked interventions to address pacemaker insertion follow up. 5-6-17 Care of Skin Cancer After Treatment from Dermatology Clinic: The tumor has been removed and over next two to three weeks we would like you to clean area with tap water, mild soap, apply petroleum jelly/Vaseline then cover with band aid. If wound bleeds hold pressure for fifteen minutes and if still bleeding take to emergency room. Wound - forehead. The HCSP lacked interventions to address wound management.	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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 8 Physician History and physical dated 7-20-17 recorded (resident) hospitalized for several weeks due to Methicillin Resistant Staphylococcus Aureus (MRSA) of forehead. Resident had three episodes of unresponsiveness which was concerning for possible seizures or TIA's. The record lacked documentation of hospitalization and the HCSP lacked interventions to address care of resident with MSRA. 9-2-17 fax to physician: Progress notes: 6-millimeter (MM) stage two ulcer to right buttock. New orders: Continue hydrogel/prim pore dressing every three days and more often if soiled. Will get cushion for wheelchair. Encourage offloading while sitting in a chair. Monitor wound size and contact if getting larger. Signed physician 9-21-17. The HCSP lacked interventions to address risks for skin breakdown and interventions to address wound management Nurses notes 2-13-18 recorded a fall and increased difficulty with transfers and notes on 2-14-18 recorded discussion with family of increased care needs and need to discharge to a higher level of care. The HCSP lacked interventions to address the resident's increased care needs and change in mobility. 2-26-18 at 4:00 p.m. observed resident in room in bed. Operator/CMA A present. Resident very weak and alert at this time. Resident stated was unable to get up out of bed without assistance of two staff. Observed oxygen via nasal cannula on	S3155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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 9 and color pale. No skin break down at this time. Resident incontinent of urine and bowel at this time. Operator/CMA stated resident was approved to go to a skilled facility due to increased level of care. Family will be here tomorrow to fill out paperwork and make arrangements. Resident understands he/she required more care and will be going to a skilled facility. Interview on 3-1-18 at 2:45 p.m. with licensed nurse I stated the FCS/NSA/HCSP did not reflect care and services resident required and confirmed no intervention/instructions for skin break down, wound with MRSA, new pacemaker, and change in health and mobility status. For residents #100 and #200, the operator failed to ensure a licensed nurse provided or coordinated the provision of necessary HCS that meet the needs of each resident and are in accordance with the FCS and the NSA	S3155		
S3171 SS=D	26-41-204 (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 26-41-204(i) The facility identified a census of 19 residents. The sample included 3 residents. Based on record review and interview for 1 (200) of 3	S3171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3171	Continued From page 10	S3171		

residents sampled, the operator failed to ensure all health care services (HCS) provided to residents by qualified staff in accordance with acceptable standards of practice when the operator/certified medication aide (CMA) communicated changes in resident health status to the physician and requested treatment without evidence the licensed nurse assessed or evaluated the resident's condition.

Findings included:

- Record review for resident #200 revealed an admit date of 3-14-14 with diagnoses of dementia, coronary artery disease, hypertension, depression and muscle weakness.

The FCS dated 3-14-16 recorded resident independent with toileting, transfer, walking/mobility, eating, continence, communication, required physical assistance with bathing and dressing, no problems with cognition, and experienced falls/unsteadiness.

The NSA dated 3-14-16 recorded resident required services for bathing, dressing/grooming, and medication set up and administration.

The HCSP dated 3-14-16 recorded resident independent with grooming, eating, ambulation, bladder continence, cognition intact, staff will assist with bathing, dressing. On 11-19-16 physical therapy for strengthening. 8-21-16 pacemaker insertion, assist as needed.

Hospital orders dated 8-5-16 for pacemaker recorded check in at the hospital at 10:00 a.m. and no eating or drinking after midnight.

Discharge instructions for permanent pacemaker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3171	Continued From page 11	S3171		

and Implantable Cardioverter Defibrillator (ICD). Do not raise elbow on the operative side above shoulder for six weeks. Do not lift greater than 5 to 7 pounds with arm on operative side for six weeks. Watch for bleeding, if bleeding starts lie down and hold pressure and get immediate medical attention. Someone needs to look at wound every day. Inspect for signs or symptoms of infection. Wear immobilizer for forty-eight hours and then at night for four weeks.

Faxed physician orders dated 1-10-17 and written by operator/CMA A recorded: "Yesterday morning resident very weak and fell frontward thankfully landing on bed. This morning after breakfast was almost to the point of being unresponsive - vital signs blood pressure (BP) 80/30, pulse (P) 58, oxygen (O2) was not picking up on oximeter, (resident) finally started answering questions - but refused to go to emergency room stating nothing can be done - however, (resident) mentioned having trouble voiding and complained of feeling so weak. Suggestions?? Thanks, operator/CMA A."

Returned fax at 10:42 recorded: 1. Check urinalysis. 2. Have no results of EEG yet. Will review and notify.

Faxed typed note to physician on 1-26-17 from operator/CMA recorded: "(Resident) is continuing to have low blood pressures causing (him/her) to have spells of becoming very limp, and a few times where (he/she) has fallen. Last evening when (he/she) had a spell B/P was 76/38 and pulse was hard to count, however, with each staff counting, one count was 36 and the other was 40. Resident was very pale. Resident is on midodrine 10 milligrams (MG) (for low B/P) taken at 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3171	Continued From page 12	S3171		

(Resident) is very discourage because was in hopes that all procedures (he/she) had done, would help with the problem, and (he/she) continues with the problem. Do you have any suggestions, or a new order, that would help (resident)?"

1-26-17 at 11:11 a.m. response from physician: hold evening dose of bumex (diuretic), then decrease to 0.5 MG one orally two times a day.

Faxed written note to physician dated 2-10-17 written by operator/CMA A recorded: "(Resident) is have a hard time with breathing. O2 is at 94. Resident wants a water pill and does not think one every other day is enough. What should we do?"

2-10-17 at 11:05 a.m. response: OK to start bumex one MG tablet daily.

Typed note to physician from operator/CMA dated 2-14-17, "Emergency Room visit on 2-13-17, resident had an incident where (he/she) was walking back from restroom and shoved walker out of (his/her) way and fell on bed. Staff helped get resident up on the bed and comfortable. Approximately an hour later resident was walking to bathroom with a staff member and resident let go of walker and threw self to floor, staff member held on as he/she lowered resident to floor. Registered Nurse (RN) came out to assess resident with no complaints other than weak and tired. This morning resident refused morning medications saying he/she is too lifeless to sit up and take them. Resident insisted on going to emergency room for evaluation of why he/she is so lifeless. Thanks, operator/CMA A."

2-14-18 response from physician: Please

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3171	Continued From page 13	S3171		

arrange a follow up appointment this week. Concern for early onset of dementia.

8-9-17 faxed to physician from operator/CMA A recorded: "(Resident) is very swollen - feet are very swollen - going up legs - weight 173 pounds. (Resident) is on bumex (diuretic) 1 MG once daily and TED hose on and would say 90% of time legs are elevated. Suggestions?

8-9-17 at 8:47 a.m. response: Weight is still down from Monday. Will increase bumex to 1 MG in morning and .5 MG at noon.

9-2-17 fax to physician: Progress notes: 6-millimeter (MM) stage two ulcer to right buttock. New orders: Continue hydrogel/prim pore dressing every three days and more often if soiled. Will get cushion for wheelchair. Encourage offloading while sitting in a chair. Monitor wound size and contact if getting larger. Signed physician 9-21-17.

The nurses notes lacked documentation for year 2016 and 2017.

2-13-18 at 10:00 a.m. Resident found in supine position on bedroom floor. Resident denied pain and stated, 'is just a wreck'. Assisted to sitting position and then to standing with gait belt. Ambulated to bed and did not want to be checked out at the clinic.

2-13-18 at 3:00 p.m. Notified of new fall in bedroom and assisted to floor by certified staff. Resident has been having increased difficulty with transfers.

2-14-18 (no time), taken to emergency room for further evaluation status/post fall. No problems

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3171	Continued From page 14	S3171		

found. Returned with no new orders or issues noted. Family called regarding check at emergency room and discussed declining health and weakness issues. Advised family that resident is requiring more assistance that this facility can provide. Will issue 30-day notice as required per policy. Family agreed with plan.

2-26-18 at 4:00 p.m. observed resident in room in bed. Operator/CMA A present. Resident very weak and alert at this time. Resident stated was unable to get up out of bed without assistance of two staff. Observed oxygen via nasal cannula on and color pale. No skin break down at this time. Resident incontinent of urine and bowel at this time. Operator/CMA stated resident was approved to go to a skilled facility due to increased level of care. Family will be here tomorrow to fill out paperwork and make arrangements. Resident understands he/she required more care and will be going to a skilled facility.

Interview on 3-1-18 at 2:45 p.m. with licensed nurse I stated the FCS/NSA/HCSP did not reflect care and services resident required and confirmed no intervention/instructions for skin break down, wound with MRSA, new pacemaker, falls/unsteadiness, shortness of breath/oxygen, edema, low blood pressure

The HCSP lacked any instructions/interventions for surgical procedure of pacemaker with ICD, falls, low B/P, oxygen/shortness of breath, care of wound on forehead with MRSA, edema, and skin break down with stage two decubitus ulcer, two-person transfer, and ambulation.

The operator/CMA sending, writing, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3171	Continued From page 15 requesting information from the medical care provider. For resident #200, the operator failed to ensure all HCS provided to residents by qualified staff in accordance with acceptable standards of practice when the operator/CMA communicated changes in resident health status to the physician and requested treatment without evidence the licensed nurse assessed or evaluated the resident's condition.	S3171		
S3201 SS=E	26-41-205 (d) (3) Facility Administration of Medication (3) A licensed nurse or medication aide shall perform the following: (A) Administer only the medication that the licensed nurse or medication aide has personally prepared; (B) identify the resident before medication is administered; (C) remain with the resident until the medication is ingested or applied; and (D) document the administration of each resident ' s medication in the resident ' s medication administration record immediately before or following completion of the task. If the medication administration record identifies only time intervals or events for the administration of medication, the licensed nurse or medication aide shall document the actual clock time the medication is administered. This REQUIREMENT is not met as evidenced by: KAR 26-205(d)(1)(D)	S3201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3201	Continued From page 16 The facility identified a census of 19 residents. The sample included 3 residents and 2 focus review residents. For 1 (#200) of 3 sampled residents and 3 (#400, #500, #600) of 3 focus review residents, the operator failed to ensure licensed nurse or certified medication aide (CMA) documented the administration of each resident's medication in the resident's medication administration record (MAR) immediately before or following completion of the task. Findings included: - On 2-26-18 at 3:15 p.m. observed CMA E setting up medications in cups on a tray. CMA E stated the medication was to give to residents at 5:30 p.m. Review of the MAR revealed at 5:30 p.m. CMA E had initialed these medications for residents #200, #400, #500, and #600 as administered. Interview on 2-26-18 at 3:30 p.m. with operator, "was not aware the medications had to be initialed immediately before or after administration." For residents #200, #400, #500, and #600, the operator failed to ensure licensed nurse or CMA documented the administration of each resident's medication in the resident's MAR immediately before or following completion of the task.	S3201		
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	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 17 results of the action This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(11) The facility identifed a census of 19 residents. The sample included 3 residents. Based on record reviews, interviews, and observations for 2 (#200 and #100) of 3 residents sampled, the operator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions taken. Findings included: - Record review for resident #200 revealed an admit date of 3-14-14 with diagnoses of dementia, coronary artery disease, hypertension, depression and muscle weakness. The FCS dated 3-14-16 recorded resident independent with toileting, transfer, walking/mobility, eating, continence, communication, required physical assistance with bathing and dressing, no problems with cognition, and experienced falls/unsteadiness. The NSA dated 3-14-16 recorded resident required services for bathing, dressing/grooming, and medication set up and administration. The HCSP dated 3-14-16 recorded resident independent with grooming, eating, ambulation,	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 18	S3261		

bladder continence, cognition intact, staff will assist with bathing, dressing. On 11-19-16 physical therapy for strengthening. 8-21-16 pacemaker insertion, assist as needed.

Faxed physician orders dated 1-10-17 and written by operator/CMA A recorded: "Yesterday morning resident very weak and fell frontward thankfully landing on bed. This morning after breakfast was almost to the point of being unresponsive - vital signs blood pressure (BP) 80/30, pulse (P) 58, oxygen (O2) was not picking up on oximeter, (resident) finally started answering questions - but refused to go to emergency room stating nothing can be done - however, (resident) mentioned having trouble voiding and complained of feeling so weak. Suggestions?? Thanks, operator/CMA A."

Returned fax at 10:42 recorded: 1. Check urinalysis. 2. Have no results of EEG yet. Will review and notify.

Faxed typed note to physician on 1-26-17 from operator/CMA recorded: "(Resident) is continuing to have low blood pressures causing (him/her) to have spells of becoming very limp, and a few times where (he/she) has fallen. Last evening when (he/she) had a spell B/P was 76/38 and pulse was hard to count, however, with each staff counting, one count was 36 and the other was 40. Resident was very pale. Resident is on midodrine 10 milligrams (MG) (for low B/P) taken at 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m. (Resident) is very discourage because was in hopes that all procedures (he/she) had done, would help with the problem, and (he/she) continues with the problem. Do you have any suggestions, or a new order, that would help (resident)?"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 19 1-26-17 at 11:11 a.m. response from physician: hold evening dose of bumex (diuretic), then decrease to 0.5 MG one orally two times a day. (The record lacked documentation of actions taken and results of actions taken) Typed note to physician from operator/CMA dated 2-14-17, "Emergency Room visit on 2-13-17, resident had an incident where (he/she) was walking back from restroom and shoved walker out of (his/her) way and fell on bed. Staff helped get resident up on the bed and comfortable. Approximately an hour later resident was walking to bathroom with a staff member and resident let go of walker and threw self to floor, staff member held on as he/she lowered resident to floor. Registered Nurse (RN) came out to assess resident with no complaints other than weak and tired. This morning resident refused morning medications saying he/she is too lifeless to sit up and take them. Resident insisted on going to emergency room for evaluation of why he/she is so lifeless. Thanks, operator/CMA A." 2-14-18 response from physician: Please arrange a follow up appointment this week. Concern for early onset of dementia. (Record lacked documentation of actions taken and results of actions taken.) 5-6-17 Care of Skin Cancer After Treatment from Dermatology Clinic: The tumor has been removed and over next two to three weeks we would like you to clean area with tap water, mild soap, apply petroleum jelly/Vaseline then cover with band aid. If wound bleeds hold pressure for fifteen minutes and if still bleeding take to	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 20	S3261		

emergency room. Wound - forehead.

History and physical dated 7-20-17 recorded (resident) accepted back in from hospital for continued skilled nursing and restorative therapy. Resident was transferred to hospital after hospitalization at a local hospital for several weeks due to Methicillin Resistant Staphylococcus Aureus (MRSA) of forehead. Resident had three episodes of unresponsiveness which was concerning for possible seizures or TIA's.

8-9-17 faxed to physician from operator/CMA A recorded: "(Resident) is very swollen - feet are very swollen - going up legs - weight 173 pounds. (Resident) is on bumex (diuretic) 1 MG once daily and TED hose on and would say 90% of time legs are elevated. Suggestions?

8-9-17 at 8:47 a.m. response: Weight is still down from Monday. Will increase bumex to 1 MG in morning and .5 MG at noon.

9-2-17 fax to physician: Progress notes: 6-millimeter (MM) stage two ulcer to right buttock. New orders: Continue hydrogel/prim pore dressing every three days and more often if soiled. Will get cushion for wheelchair. Encourage offloading while sitting in a chair. Monitor wound size and contact if getting larger. Signed physician 9-21-17.

The nurses notes lacked documentation for year 2016 and 2017.

2-13-18 at 10:00 a.m. Resident found in supine position on bedroom floor. Resident denied pain and stated, 'is just a wreck'. Assisted to sitting position and then to standing with gait belt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 21 Ambulated to bed and did not want to be checked out at the clinic. 2-13-18 at 3:00 p.m. Notified of new fall in bedroom and assisted to floor by certified staff. Resident has been having increased difficulty with transfers. (The record lacked documentation of action taken and results of actions taken.) 2-14-18 (no time), taken to emergency room for further evaluation status/post fall. No problems found. Returned with no new orders or issues noted. Family called regarding check at emergency room and discussed declining health and weakness issues. Advised family that resident is requiring more assistance that this facility can provide. Will issue 30-day notice as required per policy. Family agreed with plan. 2-26-18 at 4:00 p.m. observed resident in room in bed. Operator/CMA A present. Resident very weak and alert at this time. Resident stated was unable to get up out of bed without assistance of two staff. Observed oxygen via nasal cannula on and color pale. No skin break down at this time. Resident incontinent of urine and bowel at this time. Operator/CMA stated resident was approved to go to a skilled facility due to increased level of care. Family will be here tomorrow to fill out paperwork and make arrangements. Resident understands he/she required more care and will be going to a skilled facility. Interview on 3-1-18 at 2:45 p.m. with licensed nurse I stated the FCS/NSA/HCSP did not reflect care and services resident required and confirmed no intervention/instructions for skin	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 22	S3261		

break down, wound with MRSA, new pacemaker, falls/unsteadiness, shortness of breath/oxygen, edema, low blood pressure. The record further lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken, and results of action taken.

- Record review for resident #100 revealed an admit date of 11-11-16 with diagnoses of dementia, degenerative joint disease, insulin dependent diabetic, hypertension, gout, and chronic obstructive pulmonary disease.

The admission functional capacity screen (FCS) dated 11-2-16 and annual FCS dated 11-2-17 recorded resident independent with toileting, transfer, walking/mobility, experienced short-term memory loss, memory recall, decision making, falls/unsteadiness, and impaired vision. FCS comments: History of falls, frequent falls and family aware of problems forgetting walker and falls from chair.

The admission negotiated service agreement (NSA) dated 11-2-16 recorded resident required medication set up and independent with bathing dressing, ambulation, and toileting.

The annual NSA dated 11-11-17 recorded resident independent with ambulation and required assistance with bathing, dressing, and toileting.

The admission health care service plan (HCSP) dated 11-11-16 recorded resident independent with bathing, dressing, grooming, toileting, cognition: short-term memory loss, memory recall, impaired decision making, has impaired

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 23	S3261		

vision and wears glasses. For mobility resident has a walker and does not use regularly.

The annual HCSP dated 11-11-17 recorded resident independent with dressing, continence, and requires assist with bathing, cognition: impaired short-term memory, memory recall, impaired decision making, has impaired vision and wears glasses. For mobility resident uses a walker.

The nurses notes recorded the following:

2-8-17 at 8:30 a.m. notified by staff of fall in front of recliner in living room. Resident incontinent of feces. Resident stated could not remember what happened. Resident has an abrasion on left forearm. No other injuries noted.

(The record lacked actions taken and results of acitons taken.)

4-26-17 (no time) Notified by staff of fall in front of recliner. Resident forgot to lower the foot rest. No injuries noted. Reminded resident to use walker. Remind certified staff to remind resident to use walker at all times. Resident has history of falls.

(The record lacked actions taken and results of actions taken.)

12-5-17 at 11:30 p.m. Notified by staff of fall out of bed, found resident sitting on left side of bed in front of small night stand. Resident unsure of what happened but hit my face. Small amount of bleeding from nose. Swelling noted to left eye/nose. Family notified and took resident to hospital due to swelling. Resident ambulated to wheelchair. No other injuries noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 24 (The record lacked actions taken and results of actions taken.) 12-18-17 at 9:30 a.m. Notified by staff of all in courtyard outside. Resident followed other residents outside and checked the weather after morning meal. Resident was in sitting position with hematoma on forehead. Advised certified staff to transport to emergency room for evaluation due to pain in wrist and hematoma to forehead. Resident returned to facility with splint to right wrist and return for further evaluation. Operator visited with family about resident not being outside unattended and aware of frequent falls and possibility of need for higher level of care. (The record lacked the time resident went to hospital and return as well as actions taken and results of actions taken.) Incident reports recorded the following: 4-26-17 at 5:55 a.m. Resident found lying on floor in front of recliner with leg rest out on recliner. Resident did not put foot rest down on recliner and is not using walker. (The record lacked documentation of the actions taken and results of acitons taken) 12-5-17 at 11:00 p.m. Resident found lying on left side next to bed. Noted rug burn on forehead, lower left eye and nose swollen and bloody. Resident examined at the hospital. No fractures or breaks. Resident unable to recall if fell or rolled out of bed. Call light not in reach and forgets walker. Resident has cognitive deficit.	S3261		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3261	Continued From page 25 (The record lacked documentation of actions taken and results of actions taken.) 12-18-17 9:30 a.m. Found resident outside sitting on the ground. Resident complained of pain in right wrist with poor range of motion. Observed a knot on forehead and right wrist. Resident sent to hospital with hematoma on forehead and returned with a splint on right wrist. Unwitnessed fall and resident has cognitive issues with history of falls. Walker was left in dining room. Family aware of falls. (Record lacked time resident returned from hospital actions taken and results of acitons taken.) Interview on 3-1-18 at 2:30 p.m. with licensed nurse I stated and confirmed the record lacked documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, action taken and results of actions taken. For residents #200 and #100, the operator failed to ensure documentation of all incidents, symptoms, and other indications of illness or injury including the date, time of occurrence, actions taken, and results of the actions taken.	S3261		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan;	S3280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N039004	A. BUILDING: _____ B. WING _____	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY LIVING, INC	420 N 5TH ANTHONY, KS 67003

(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
S3280	Continued From page 26 (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility identified a census of 19 residents. The sample included 3 residents. For all residents, the operator failed to ensure a quarterly review of the facility's emergency management plan with residents. Findings included: - Review of emergency and disaster plan on 2-26-18 at 12:05 p.m. revealed the plan reviewed with employees only. Interview on 2-26-18 at 12:10 p.m. with operator stated, "He/She had not conducted an annual review with residents as they would not remember reviewing the plan." For all residents, the operator failed to ensure a quarterly review of the facility's emergency management plan with residents.	S3280		