STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N067010	A. BUILDING: _____ B. WING _____	05/31/2017

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COUNTRY PLACE SENIOR LIVING OF CHANUTE	701 OSA MARTIN BLVD CHANUTE, KS 66720

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S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey at the above named facility on 5-24-17, 5-25-17, 5-30-17, and 5-31-17.	S 000		
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: KAR 26-41-204(a) The facility identified a census of 25 residents. The sample included 3 residents. Based on record review, interview and observations for 1 (100) of 3 residents sampled, the administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary Health Care Services (HCS) that meet the needs of resident #100 in accordance with the Functional Capacity Screen (FCS) and the Negotiated Service Agreement (NSA). Findings included: - Record review for resident #100 revealed an admission date of 5-11-17 with diagnoses of insulin dependent diabetic, stroke, and failure to thrive.	S3155		

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

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S3155	Continued From page 1 The FCS dated 5-11-17 recorded resident independent with cognition, communication, required supervision for eating, physical assistance with bathing dressing, toileting, transfer, walking/mobility, bladder incontinence, unable to manage medications and treatments, experienced falls/unsteadiness, impaired hearing and vision. The NSA/Health Care Service Plan (HCSP) dated 5-10-17 recorded resident required total assistance with bathing and hospice aide will assist. Total assistance with hygiene/grooming, physical assistance with dressing, toileting, transfer, staff to use gait belt when transferring resident and may require two staff assistance with transfers. Resident will have a personal alarm and visual reminders to call staff for assist with transfers. Resident uses wheelchair for mobility and requires staff to push in wheelchair. Staff to administer medications and resident can self-administer insulin. If resident unable to self-inject insulin then family or nurse will administer insulin. Staff to check skin areas as delegated by nurse and report any signs/symptoms of redness, skin breakdown or infection. Resident has moderate impairment of long or short term memory; may appear to be functional on surface but detailed conversation revealed problems of withdrawal, depression, isolation and required strong reminders. Is oriented to self but has difficult with time and place; need reoriented through the day. Resident has a pressure sore to his/her bottom. Staff to reposition, have hospital bed with air mattress, a personal alarm and visual reminders to call for assistance with transfers. Interview on 5-24-17 at 11:55 a.m. with resident	S3155		

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S3155	Continued From page 2 #100 stated he/she was hungry. Resident visiting with other residents in commons area. Resident observed sitting on pressure relief cushion in wheelchair and oriented to self. On 5-24-17 at 1:05 p.m. observed certified staff A and B take resident #100 from dining room to room for toileting and noted chair alarm in place. Certified staff A and B attempted to transfer resident #100 from wheelchair to toilet. Resident complained of pain in left knee and stated it hurt all morning. Certified staff A and B was unable to transfer resident due to him/her yelling out in pain and unable to bear weight on left leg. Resident was placed back in wheelchair. Licensed nurse C present during attempted transfer and then left room to notify hospice nurse of pain in resident's left knee. Certified staff A left room and came back with liquid roxanol (for pain) and administered to resident. Certified staff A and B then continued to transfer resident to bed from wheelchair without weight bearing to left leg. Resident yelled out in pain during transfer and during incontinent care. Certified staff C applied calmoseptine to one Centimeter (CM) open area on coccyx after providing incontinent care. Left leg positioned on rolled up blanket. Resident moaning and complained of left leg pain. Call light placed in reach. Certified staff A and B left the room. Surveyor observed body alarm not on resident, two half side rails up on bed, and no visual signs to have resident call for assistance. On 5-24-17 at 1:45 p.m. asked certified staff to come to resident #100's room and he/she confirmed resident did not have a body alarm in place and no visual signs present for resident to call for assistance. Resident resting quietly at this time.	S3155		

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S3155	Continued From page 3 Interview on 5-24-17 at 1:50 p.m. with licensed nurse C stated he/she called hospice nurse and they will come and assess resident. Resident had not experienced a fall that he/she was aware of and would have to send resident to hospital to get an x-ray of left knee and hospice would have to approve. Licensed nurse C also stated resident had a pressure ulcer on coccyx since admission and the treatment would be recorded on the Medication Administration Record (MAR). He/she thought it was calmoseptine. Review of MAR lacked documentation of calmoseptine applied to coccyx pressure ulcer. The record also lacked an order for calmoseptine treatment for pressure ulcer on coccyx. Licensed nurse C also confirmed resident did not have a body alarm place after staff transferred resident from wheelchair to bed, no visual signs present for resident to call for assistance to get up and had two half side rails on bed without side rail assessment or identified in the NSA/HCSP. On 5-25-17 at 9:45 a.m. surveyor went to resident #100's room and noted resident in bed with family member present. Family member stated was concerned about resident's left knee pain and did not want resident sent to hospital for x-ray today. The family member wanted to see if the pain got better in a day or two and wanted to just give resident ibuprofen for pain. Family member met with hospice and facility staff this morning and was informed doctor ordered ultram (for pain) and still had roxanol (for pain) if needed. Interview on 5-25-17 at 10:15 a.m. with certified staff A stated resident complained of pain in left knee when was instructed to get resident up this morning for breakfast. For resident #100, the administrator failed to	S3155		

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S3155	Continued From page 4 ensure the licensed nurse coordinated the provision of necessary HCS for signs/symptoms pain or injury to left knee when resident yelled out and complained of pain in left knee when moved, failed to ensure stage 2 pressure ulcer treatment provided, body alarm applied when resident in bed, visual signs available to have resident call for assistance to get up and failed to ensure the NSA/HCSP contained a description of use for side rails for cognitive impaired resident and assessment of use for side rails.	S3155		
S3200 SS=D	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: KAR 26-41-205(d)	S3200		

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S3200	Continued From page 5 The facility identified a census of 25 residents. The sample included 3 residents. Based on record review and interview for 1 (#100) of 3 residents sampled, the administrator failed to ensure that all medications and biologicals are administered to resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations. Findings included: - Record review for resident #100 revealed an admission date of 5-11-17 with diagnoses of insulin dependent diabetic, stroke, and failure to thrive. The FCS dated 5-11-17 recorded resident unable to manage medications and treatments. The NSA/Health Care Service Plan (HCSP) dated 5-10-17 recorded facility staff to administer medications and resident can self-administer insulin. If resident unable to self-inject insulin then family or nurse will administer insulin. Is on hospice and has pressure sore on bottom. Interview on 5-24-17 at 11:55 a.m. with resident #100 stated he/she was hungry. Resident visiting with other residents in commons area. Resident observed sitting on pressure relief cushion in wheelchair and oriented to self. On 5-24-17 at 1:05 p.m. Certified staff C applied calmoseptine (for wound care) to one Centimeter (CM) open area on coccyx after providing incontinent care. Interview on 5-24-17 at 1:50 p.m. with licensed nurse C stated resident should have	S3200		

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S3200	Continued From page 6 calmoseptine documented in the medication administration record (MAR) for pressure ulcer on coccyx. Licensed nurse C reviewed the MAR and confirmed calmoseptine not on the MAR and further confirmed did not have a treatment order for pressure ulcer on coccyx. For resident #100, the administrator failed to ensure that all medications and biologicals are administered to resident in accordance with a medical care provider's written order, professional standards of practice, and each manufacturer's recommendations.	S3200		
S3215 SS=E	26-41-205 (h) Medication Storage (h) Storage. Licensed nurses and medication aides shall ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer ' s recommendations or those of the pharmacy provider and with federal and state laws and regulations. (1) Licensed nurses or medication aides shall store non-controlled medications and biologicals managed by the facility in a locked medication room, cabinet, or medication cart. Licensed nurses and medication aides shall store controlled medications managed by the facility in separately locked compartments within a locked medication room, cabinet, or medication cart. Only licensed nurses and medication aides shall have access to the stored medications and biologicals. (2) Each resident managing and self-administering medication shall store medications in a place that is accessible only to the resident, licensed nurses, and medication aides.	S3215		

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S3215	Continued From page 7 (3) Any resident who self-administers medication and is unable to provide proper storage as recommended by the manufacturer or pharmacy provider may request that the medication be stored by the facility. (4) A licensed nurse or medication aide shall not administer medication beyond the manufacturer ' s or pharmacy provider ' s recommended date of expiration. This REQUIREMENT is not met as evidenced by: KAR 26-41-205(h) The facility identified a census of 25 residents. The sample included 3 residents and 2 non-sampled residents. Based on observation and interview for 2 (444 and #555) of 2 non-sampled residents, the licensed nurses and medication aides failed to ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations. Findings included: - Tour of medication room on 5-24-17 at 10:00 a.m. revealed a refrigerator that contained two novolog insulin pens "in use". One identified novolog insulin pen for resident #444 opened on 5-17-17 and one novolog insulin pen for #555 opened on 4-21-17. Interview on 5-24-17 at 10:10 with certified medication aide (CMA) A stated both novolog insulin pens was "in use" and stored in the	S3215		

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S3215	Continued From page 8 refrigerator. Manufacturer's recommendations recorded to store "in use" novolog insulin pens at room temperature and store unopened insulin pens in the refrigerator. (CMA) A reviewed manufacturer's recommendations and confirmed. For non-sampled residents #444 and #555, the licensed nurse and CMA's failed to ensure that all medications and biologicals are securely and properly stored in accordance with each manufacturer's recommendations or those of the pharmacy provider and with federal and state laws and regulations.	S3215		
S3299 SS=F	26-41-206 (e) (1) Facility Food Storage (e) Food storage. Facility staff shall store all food under safe and sanitary conditions. (1) Containers of poisonous compounds and cleaning supplies shall not be stored in the areas used for food storage, preparation, or serving. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(e) The facility identified a census of 25 residents. The sample included 3 residents. Based on observations and interviews for all residents, the administrator failed to ensure all food items stored under safe and sanitary conditions and failed to ensure container of poisonous compounds and cleaning supplies not store in the areas used for food storage, preparation, or serving.	S3299		

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S3299	Continued From page 9 Findings included: - On 5-24-17 at 10:30 a.m. observed dietary manager G making strawberry cheese caked. The center island contained a sink with a cabinet under the sink. The cabinet under the sink contained gallon containers of vinegar, vegetable oil, soy sauce, and professional combined pan blaster. Dietary staff stated the pan blaster was to get rust and hard to remove food off pans. On the bottle of pan buster identified a warning harmful if swallowed. Dietary staff removed the chemical from the cabinet. The freezer contained the following opened packed foods in plastic without date opened or food identified, ego ' s, 5 packages aluminum foil wrapped frozen bacon, frozen egg noodles, frozen yeast rolls, and beef/chicken patties, and French garlic breads. Dietary manager G confirmed foods not dated, identified, or stored properly. For all residents, the administrator failed to ensure all food items stored under safe and sanitary conditions and failed to ensure container of poisonous compounds and cleaning supplies not store in the areas used for food storage, preparation, or serving.	S3299		